

# DRC INTEGRATED HIV/AIDS PROJECT

## PROJET INTEGRE DE VIH/SIDA AU CONGO (PROVIC) YEAR 2 ANNUAL REPORT

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## ACRONYMS AND ABBREVIATIONS

ACOSYF	<i>Association Coopérative en Synergie Féminine</i>
AIDS	acquired immune deficiency syndrome
ALUDROFE	<i>Association de lutte pour la promotion et la protection des droits de la femme et de l'enfant</i>
AMO-Congo	<i>Avenir Meilleur pour les Orphelins au Congo</i>
ART	antiretroviral therapy
ARV	antiretroviral
ASF	<i>Association de Santé Familiale</i> (Population Services International)
AZT	azidothymidine
BAK-Congo	Bread and Knowledge Too
BCC	behavior change communication
C2C	child-to-child
C-Change	Communication for Change
CEMAKI	<i>Centre Maman Kinzembo</i>
CSR	<i>Centre de Santé de Référence</i>
CSW	commercial sex worker
DCIP	dichlorophenolindophenol
DIVAS	<i>Division des Affaires Sociales</i>
DRC	Democratic Republic of Congo
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FANTA	Food and Nutrition Technical Assistance
FFP	<i>Fondation Femme Plus</i>
FY	Fiscal Year
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV counseling and testing
HGR	<i>Hopitale General de Référence</i>
HIV	human immunodeficiency virus
ICT	information and computing technology
IGA	income-generating activity
IR	Intermediate Result
JADISIDA	<i>Jeunesse Active pour le Développement Intégré et lutte contre le VIH/SIDA</i>
LIFT	Livelihood and Food Security Technical Assistance
M&E	monitoring and evaluation
MARP	most-at-risk population
MINAS	<i>Ministère des Affaires Sociales</i>
MSH	Management Sciences for Health
MSM	men who have sex with men
NASA	National AIDS Spending Assessment
NGO	nongovernmental organization
OLASEC	<i>Organisation non Gouvernementale Laïque a la Vocation Socio-Economique du Congo</i>
OVC	orphans and vulnerable children
PATH	Program for Appropriate Technology in Health
PCR	polymerase chain reaction
PEPFAR	United States President's Emergency Plan for AIDS Relief

PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission of HIV
PNLS	<i>Programme National de Lutte contre le SIDA</i>
PNMLS	<i>Programme Nationale Multi-Sectorielle de Lutte contre le SIDA</i>
PNSR	National Reproductive Health Program
PROSANI	<i>Projet Intégré de Sante</i> (Integrated Health Project)
ProVIC	<i>Projet Intégré de VIH/SIDA au Congo</i> (Integrated HIV/AIDS Project)
PSI	Population Services International
PSSP	<i>Progrès Santé Sans Prix</i> (Progress and Health Without a Price)
RIG	Regional Inspector General
RNOAC	<i>Réseau National des Organisations d'Assise Communautaire</i>
SCMS	Supply Chain Management System
SPS	Strengthening Pharmaceutical Systems (Management Sciences for Health)
STI	sexually transmitted infection
STTA	short-term technical assistance
SWAA	Society for Women and AIDS in Africa
TB	tuberculosis
TIFIE	Teaching Individuals and Families Independence through Enterprise
TOT	training of trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## EXECUTIVE SUMMARY

*Projet Intégré de VIH/SIDA au Congo* (Integrated HIV/AIDS Project, or ProVIC) is pleased to present its Year 2 annual report, covering the period October 2010 through September 2011. ProVIC's mission in the Democratic Republic of Congo (DRC) is to reduce the incidence and prevalence of HIV and mitigate its impact on people living with HIV/AIDS (PLWHA) and their families in the four provinces where ProVIC operates (Bas Congo, Katanga, Kinshasa, and Sud Kivu). Underlying this stated purpose is a deeper vision and engagement process that constitutes the core strategy and driving force of ProVIC: the creation of "Champion Communities" and the integration of supportive HIV/AIDS services so that Congolese citizens can become masters of their own future through the progressive, deliberate, and participatory practice of communities engaging in the collective definition and resolution of their own problems.

In Fiscal Year (FY) 2011, ProVIC continued to solidify and expand the basis for this sustainable change. In spite of a highly complex and dynamic environment across the four project-supported provinces, ProVIC built on FY2010 foundations and expanded a wide spectrum of community-based prevention, care, and support and prevention of mother-to-child transmission of HIV (PMTCT) and HIV counseling and testing (HCT) programs that largely met intended targets. In doing so, ProVIC met its technical objectives of introducing innovative practices to the DRC, such as the initiation of 40 Champion Communities, PMTCT triple therapy, and mobile HCT for most-at-risk populations (MARPs; e.g., commercial sex workers, truck drivers, and miners), while also integrating essential services into many of the DRC's largest health facilities and working at the national level to improve policies, tools, and training materials. ProVIC has become a technical and programmatic leader in the HIV/AIDS response in the DRC, both by its ongoing role in consulting with national and governmental technical leaders and by its results on the ground.

Operating in 27 health zones, ProVIC partners tested 162,710 people via HCT services—108 percent of target. In addition, ProVIC offered PMTCT counseling and testing services to 28,336 pregnant women (123.2 percent) through 22 health facilities, including 13 public-sector hospitals and clinics. Through 40 Champion Communities, ProVIC partners reached 543,940 individuals with HIV prevention messages (151 percent of target), including 74,319 MARPs. To deliver essential services to PLWHA and orphans and vulnerable children (OVC), ProVIC partners established 149 self-help groups and 94 child-to-child groups. These groups were the primary means of providing care and support services to 17,866 PLWHA and OVC, including clinical services.

## INTRODUCTION

*Projet Intégré de VIH/SIDA au Congo* (Integrated HIV/AIDS Project, or ProVIC) operates in a highly complex and diverse environment across four provinces of the Democratic Republic of Congo (DRC), a country that was at the center of a continental war less than a decade ago, and which by many measures, operates as a “collapsed state.” While the HIV prevalence rate remains relatively low at 1.3 percent, the impact of the epidemic is amplified by the DRC’s large population (67.8 million) and extreme poverty. Due to the very weak health system, only a small fraction of individuals who are eligible for antiretroviral medications (ARVs) or other services receive them. The burden of the HIV/AIDS epidemic in the DRC is increasingly falling on women, leading ProVIC to tailor its interventions to that need. Sixty-nine percent of ProVIC’s care and support services are focused on women and girls, including 62 percent of nutritional support services. ProVIC is also working actively to increase male participation in critical activities such as prevention of mother-to-child transmission of HIV (PMTCT) and HIV counseling and testing (HCT), with 54 percent of individuals tested being men, primarily due to ProVIC’s focus on truck drivers and miners.

ProVIC’s comprehensive HIV/AIDS activities were designed based on international standards and in response to the environment of the DRC. The international standards were adapted to the languages, cultures, and localized drivers of the epidemic in the four provinces in which it operates—Bas Congo, Katanga, Kinshasa, and Sud Kivu—home to the 10 Champion Communities around which ProVIC’s activities are centered.

In the western province of Bas Congo, ProVIC works in Matadi, the DRC’s major port town. ProVIC works along the major transportation axis with truck drivers and commercial sex workers (CSWs), as well as Matadi’s largest health structures.

In the province of Katanga, which is characterized by its industrial and artisanal mining and trucking operations, ProVIC’s work is focused on the provincial capital of Lubumbashi and the copper belt trucking route from Kolwezi to the border town in Kasumbalesa, where ProVIC partners work intensively with truck drivers, CSWs, and bar owners along the DRC-Zambia border, where copper-carrying trucks often wait weeks to cross the border en route to South Africa.

The province of Kinshasa is dominated by the bustling capital of Kinshasa, with its dense urban population of 12 million inhabitants. Residents of Kinshasa have better access to health facilities and trained health personnel than residents of other parts of the country. ProVIC’s Kinshasa operations are highlighted by innovative nighttime mobile HCT services, which target high-risk male and female CSWs, as well as activities in two of the DRC’s largest maternities—Kingasani and Binza—which were among the first partners in the DRC to integrate the new PMTCT guidelines (using combination regimens for the most effective prevention) for pregnant women with HIV. ProVIC has also integrated provider-initiated counseling and testing into both public and private health facilities.

Ongoing security and political instability in Sud Kivu province creates an environment of great risk for women, as widespread rape remains an extension of localized conflict. ProVIC’s work in the provincial capital of Bukavu, and in Uvira on Lake Tanganyika, focuses on nongovernmental

organizations (NGOs) that promote women's empowerment. ProVIC supports prevention and counseling and testing of high-risk groups of truck drivers and fishermen.

## **Progress toward results**

### **ProVIC Year 2 achievement highlights**

#### **Community mobilization**

- ❖ 543,940 of the targeted population were reached with individual and/or small group-level preventive interventions. A total of 74,621 most-at-risk individuals, including 24,381 truck drivers, 14,965 miners, 17,020 commercial sex workers, 5,158 fishermen, and 1,323 men who have sex with men, were reached.

#### **HIV counseling and testing**

- ❖ 162,710 people received counseling and testing services for HIV, including their test result.

#### **Prevention of mother-to-child transmission of HIV**

- ❖ 28,336 pregnant women were tested for HIV, and of those who were HIV positive, 445 received antiretroviral therapy to reduce the risk of mother-to-child transmission.

#### **Pediatric support**

- ❖ 187 infants benefited from early infant diagnosis of HIV.

#### **Care and support**

- ❖ 20,310 eligible adults and children were provided with psychological, social, or spiritual support.

#### **Health systems strengthening**

- ❖ 342 health care workers successfully completed in-service training programs.

## **SECTION 1: REPORTS BY TECHNICAL COMPONENT**

### **Intermediate Result 1: HCT and prevention services expanded and improved in target areas**

#### **Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened**

##### ***Summary of activities and achievements in Year 2***

The foundation of ProVIC's interventions is the Champion Community approach, through which ProVIC assists communities affected by HIV/AIDS to self-organize, self-assess, and self-plan their own community-level response. The Champion Community model, as adapted to the DRC, is showing strong promise, interest, and participation in the uptake of utilization of HIV services. The government at the local, provincial, and national levels has expressed appreciation for, and interest in, the Champion Community model, as it is one of the only community-based HIV models still operational in the DRC.

In Fiscal Year (FY) 2011, ProVIC initiated the Champion Community process in 40 communities by assisting them to identify problems, set goals, develop action plans, and monitor progress, particularly with regard to health outcomes for the most vulnerable populations: orphans and vulnerable children (OVC) and PLWHA. This approach begins with the mobilization of community resources, such as political, religious, community, business, and civil society leaders, and obtains their support of this community-driven approach. The next steps involve creating and building the capacity of steering committees comprised of representatives from various populations and interest groups at all levels of the community. Each steering committee works to identify problems, define priorities, negotiate objectives, and develop action plans, and signs an agreement supporting their plans. At this point, implementation begins and is accompanied by monitoring and evaluation (M&E) processes. Finally, each community conducts a self-evaluation and celebrates its collective achievements.

During the first half of Year 2, ProVIC focused its programs on building a strong foundation in order to successfully implement the Champion Community approach in the selected communities. Sensitization and mobilization interventions were designed by ProVIC staff and implemented to help individuals, families, and communities to change and adopt responsible and healthy behavior with regard to HIV/AIDS. In total, 543,940 individuals across the four project provinces were reached with HIV prevention messages. Working with 14 grantees and local organizations and leveraging expertise of ProVIC staff in the four provinces, the 40 Champion Communities were actively involved in the identification of internal and local resources to resolve problems. Raising the awareness of the communities around their capacity to identify local problems and resolve them by first using local resources has opened the way to ownership and sustainability of activities currently implemented with ProVIC funding. It has also increased the demand for high-quality health services, as a direct link has been established between communities and health services.

##### ***Adapting and validating the Champion Community approach for the DRC***

Under the auspice of *Programme Nationale Multi-Sectorielle de Lutte contre le SIDA* (PNMLS), a meeting was held in October 2010 between the major actors participating in the Champion

Community process to discuss the approach and its contextualization to local realities in the DRC. Participants included representatives from government organizations (*Programme National de Lutte contre le SIDA* [PNLS], the Ministry of Interior and Decentralization, and *Ministère des Affaires Sociales* [MINAS]), the World Health Organization (WHO), implementing partners (Communication for Change [C-Change], Population Services International [PSI], Cordaid, Sanru, and Management Sciences for Health [MSH]), and local partners (*Fondation Femme Plus* [FFP], Society for Women and AIDS in Africa [SWAA], *Progrès Santé Sans Prix* [PSSP], Avenir Meilleur pour les Orphelins au Congo [AMO-Congo], Teaching Individuals and Families Independence through Enterprise (TIFIE Humanitarian), and *Réseau National des Organisations d'Assise Communautaire* [RNOAC]). After a robust discussion, the possibilities for leveraging existing resources in the communities were explored to ensure active participation of the communities and ensure sustainability. Outcomes of the discussion were presented and adopted, then incorporated into the Champion Community approach to guide current and future actions.

This participatory process was intended to ensure that the implementation of the Champion Community approach will fit within the context of the DRC. The involvement of stakeholders in the adaptation and validation of the model helped ProVIC to secure the necessary buy-in and support from government and community leaders. At the end of this meeting, the Champion Community approach was fully endorsed by participants for the DRC.

### ***Finalizing the selection of NGO partners that will implement the approach***

As much of ProVIC's work through Champion Communities will be done through local NGOs, it was necessary to complete a grant selection process in line with United States Agency for International Development (USAID) competition rules. Throughout the first quarter of Year 2, ProVIC worked to identify appropriate organizations to implement the Champion Community approach. This was done through a Request for Applications/program statement to solicit grant applications from interested organizations. Organizations were invited to submit grant proposals to ProVIC, and ProVIC provided technical and financial assistance to ensure proposals received were in line with our vision of the Champion Community approach. Information sessions were held in all four provinces, led by regional coordinators with support from relevant technical specialists based in Kinshasa. The sessions emphasized ProVIC's desire to select proposals that valued innovation, integration, and sustainability.

In the end, 14 proposals were selected based on the following evaluation criteria:

- Quality of the implementation methodology.
- Appropriateness of proposed activities.
- Impact of proposed activities toward attaining the results.
- Budget.
- Potential sustainability of the interventions.

The 14 organizations selected are either fully integrated into or familiar with the communities targeted for implementation of the Community Champion approach: AMO-Congo, Bread and Knowledge Too (BAK-Congo), SWAA, PSSP, *Bureau Diocésain des Oeuvres Médicales*,

*Jeunesse Active pour le Développement Intégré et lutte contre le VIH/SIDA (JADISIDA), RNOAC, FFP, Organisation non Gouvernementale Laïque a la Vocation Socio-Economique du Congo (OLASEC), Centre Maman Kinzembo (CEMAKI), Association Coopérative en Synergie Féminine (ACOSYF), TIFIE Humanitarian, World Production, and Association de lutte pour la promotion et la protection des droits de la femme et de l'enfant (ALUDROFE). The grants were approved by USAID on February 2, 2011.*

### ***Preparing the baseline study***

Following selection of grantee partners, a training of trainers (TOT) workshop on conducting a baseline evaluation was held in Kinshasa January 6–9, 2011. Fourteen ProVIC staff, including regional coordinators, M&E specialists, and Kinshasa-based technical staff participated in the TOT. With the support of PATH's Washington, DC-based M&E specialist, the trainers were taught the standards and norms of conducting a baseline study, taking into account the different types of investigators and communities being surveyed.



*Baseline session with members of the community.*

Following the TOT, a qualitative survey was conducted in eight Champion Communities to better identify issues and understand the perception of participating communities toward HIV/AIDS. The investigators were trained in participative methodology and how to use visual tools such as community mapping, a polarization diagram, a problem-solving tree, and an OVC poster on data collection.

### ***Developing tools and materials for Champion Community implementation***

In order for the ProVIC technical team to better understand the Champion Community approach, a study tour to Champion Community sites in Madagascar was conducted with a mixed team of ProVIC staff, PNMLS, and partners. During the course of the two-week tour, the group was able to:

- Develop a solid understanding of the Champion Community model and skills to ensure its introduction to, ownership by, and implementation in the DRC.
- Learn from challenges faced in Madagascar in the implementation of the model.
- Learn from people and organizations directly involved in the implementation, people who have lived the approach over the years and have used it to achieve solid results.
- Explore integration of the model at the national, regional, and local levels to understand how it can be taken to scale.

Experiences and lessons learned from the study tour were used by the group to facilitate the process of adaptation and ownership of the model, its tools, and guidelines for the DRC. These tools were made available to partners in all Champion Communities, with the help of regional coordination offices.

### ***Training partners in the Champion Community approach***

After completion of the baseline evaluation and development and distribution of the tools, ProVIC cascaded training down to the community level. The ProVIC community mobilization specialist worked with two international consultants in January 2011, simultaneously holding two parallel TOT workshops on the Champion Community approach, in Kinshasa and Lubumbashi. The framework of the training was based on the principles and methodology for adult learning (andragogy) and the experiential model. Twenty-nine trainers in Kinshasa and 31 in Lubumbashi were trained in skills and knowledge on adult learning methodology. At the end of the workshops, each regional team developed a tailored implementation plan to show how skills and knowledge acquired would be used in their community.



*Community workers in Matadi after distribution of sensitization kits by JADISIDA.*

The TOTs provided ProVIC with a pool of trainers in all four provinces to effectively facilitate the implementation and ownership of the Champion Community approach and assist partner organizations in the implementation of their planned activities.

### ***Developing BCC materials***



*USAID delegation meeting with the steering committee in Biyela, Kinshasa.*

In Year 2, existing BCC materials and tools previously validated by the PNLS were identified and analyzed in collaboration with C-Change, USAID's principle communications partner in the DRC. These materials were distributed to peer educators in all Champion Communities and include image boxes, pamphlets, and messages on HIV.

### ***Supporting implementation of the Champion Community approach***

ProVIC implemented 40 Champion Communities by selecting sites, issuing grants to 14 implementing partners, and signing partnership agreements with health facilities.

From there, the Champion Community approach was rolled out, including the election and training of steering committee members, the identification and training of 1,200 community workers (30 in each Champion Community), organization of community meetings to identify and prioritize problems, setting objectives, targets and developing action plans, implementing

activities, monitoring; community review of progress; evaluation and collective celebration of achievements.

Those 600 steering committee members were trained in the Champion Community approach and provided with skills to execute their roles and responsibilities within Champion Communities. The training focused on the Champion Community methodology; the fight against HIV/AIDS; planning, implementation, and monitoring processes; and conducting effective and productive advocacy interventions. Training activities were organized and facilitated by grantees in collaboration with PNMLS, the PNLs, and MINAS. In addition, 1,200 community workers were trained (30 in each Champion Community) in different aspects of HIV/AIDS, community mobilization, interpersonal communication, and how to reach out to marginalized and vulnerable groups.



*A PSSP PLWHA peer educator demonstrating condom use.*

In order to encourage intensified community involvement, participative planning meetings were organized in all 40 Champion Communities. They included the members of the steering committees, implementing partners, community leaders, administrative and religious authorities, and community workers. Each community developed an action plan with specific objectives to be achieved during the implementation period. Community members trained in community assessment led the identification of priority needs of the community, including those of PLWHA, OVC, and their families, setting objectives and implementation of activities.



*Theatrical performance on HIV in Biyela, Kinshasa.*

reached with BCC messages and interventions (see Figures 1 and 2 below). ProVIC benefited greatly from using the Joint United Nations Programme on HIV/AIDS risk assessment mapping documents for Kinshasa and Matadi.

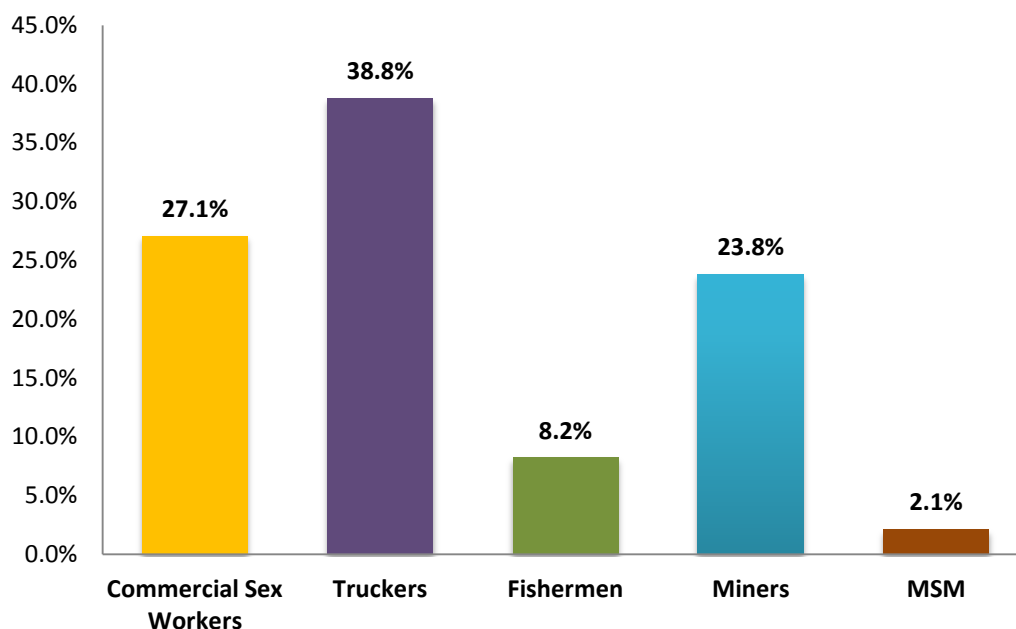
Sensitization activities stressing behavior change were organized in each community through focus groups, door-to-door outreach, interpersonal communication, and peer education. Different topics regarding PMTCT, prevention, HCT, stigmatization, family planning, gender-based violence, and care and support for PLWHA and OVC were discussed during these activities.

As the result of ProVIC's interventions, 103,908 youth were reached with messages on abstinence and being faithful; 543,940 persons in the general population were sensitized on HIV; and 74,621 MARPs were

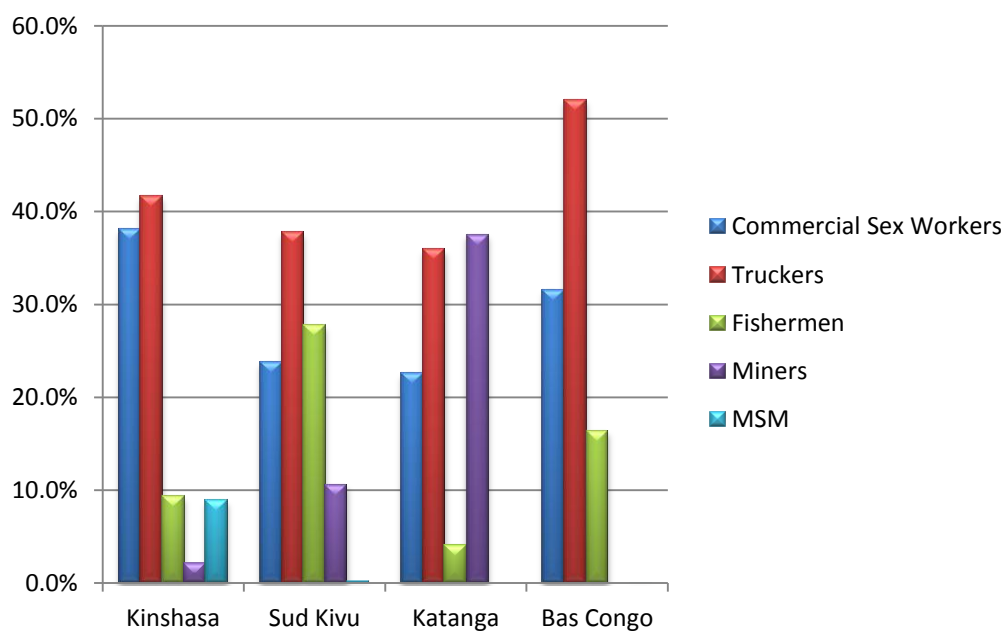
Another achievement was the development of a network of 50 men who have sex with men (MSM) in Kinshasa who are actively involved in the identification and sensitization of their peers and communication for behavior change. In partnership with TIGO, one of the cellular

phone companies operating in the DRC, sensitization messages on HIV stressing “abstinence, be faithful, and use condoms” to prevent infection with HIV and other sexually transmitted infections (STIs) were sent by SMS to subscribers throughout the country. About 2.3 million people were reached with these messages.

**Figure 1. Distribution of MARPs reached with individual and/or small group-level interventions that were based on evidence and/or met the minimum standards required.**



**Figure 2. Distribution of MARPs reached by category and province, reflecting the distribution of risk factors by province.**



The United States President's Emergency Plan for AIDS Relief (PEPFAR) ambassador, Eric Goosby, and United States ambassador to the DRC, James Entwistle, and his wife visited ProVIC Champion Communities in Year 2. The honored guests had the opportunity to appreciate the level of commitment and engagement of the communities visited (Biyela, Kinshasa, and Kinzau-Mvute, Bas Congo), as well as the synergy displayed in the implementation of activities. Ambassador Entwistle and his wife made headlines by inaugurating mobile testing tents in Bas Congo and receiving HIV couples counseling and testing and thereby demonstrating positive behaviors to other couples in Bas Congo. Each Champion Community conducted quarterly internal progress evaluations during Year 2, which provided an opportunity for steering committee members to share experiences, identify successes and lessons learned, and develop strategies for improvement.



*PEPFAR ambassador Eric Goosby with the mayor of Kimbanseke, national coordinator of SWAA, viewing foodstuffs produced by PLWHA in Biyela, Kinshasa.*

External evaluations were conducted by a team from PNMLS, the PNLs, and *Division des Affaires Sociales* (DIVAS) to measure progress toward objectives set by each Champion Community. By the end of Year 2, 18 of 40 Champion Communities had been evaluated. The remaining will be evaluated in November 2011. One of the findings was that more needs to be done for the approach to be owned by communities. Of the 18 evaluated, 16 were certified "Champion."

### ***Challenges and proposed solutions***

- To ensure sustainability of community action while progressively reducing project financial inputs is central to ProVIC's operational research this year. ProVIC contracted an international consultant familiar with the Champion Community approach to look at progress as well as how to sustain the communities over time.
- Motivation for community participants who expect financial compensation for their efforts is a challenge, and it leads to a reduction in participation among many over time. ProVIC is trying to establish an internal, sustainable means of motivating community volunteers. This will also be examined by the consultant.
- Synergies need to be developed with other donors/projects and the private sector to introduce a wider base of development actions into the Champion Communities.



*Internal evaluation meeting in Uvira, Sud Kivu (Kimanga Champion Community).*

ProVIC is in discussions with PSI and will seek other partners, public and private, to use the Champion Community platform for their interventions.

## **Sub-IR 1.2: Community- and facility-based HCT services enhanced**

### ***Summary of activities and achievements in Year 2***

In FY2011, ProVIC tested 162,710 individuals via facility-based, community-based, and mobile HCT services, primarily in and around Champion Communities, across the 27 health zones in which ProVIC operates (see Table 2 below for a list of ProVIC HCT sites and Table 3 for the results). A total of 4,731 tested HIV positive—a 2.8 percent prevalence rate, or more than double the estimated national average of 1.3 percent (as reported in the 2007 Demographic and Health Survey). ProVIC was able to test this relatively high percentage due to the targeting of MARPs, including 6,760 CSWs and 1,081 MSM. Sixty-nine percent of the 162,710 individuals tested were reached through the use of mobile HCT services working day and night to provide services to MARPs and their partners in urban and remote areas. Nineteen percent of those tested were reached through community HCT, and 12 percent were reached through integrated HCT (see Figure 3 below).



*ProVIC outreach workers offering mobile HCT services to vulnerable groups in Kinshasa.*

In FY2011, ProVIC worked in collaboration with the PNLS and PNMLS to reinforce the capacity of HCT providers and conducted routine joint formative supervision. Key staff in HCT sites were trained, provided with regular supervision, and supplied with HCT commodities to ensure consistent availability of HCT services to clients, with the exception of two one-month stockout periods due to difficulties with importing testing supplies. ProVIC partners were organized into a network by city to leverage resources and respond to increased demand for HCT services, much of which is now directed to ProVIC due to the departure of other donor-supported programs, such as the World Bank Multi-Country

HIV/AIDS Program, and the freeze on Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) operations.

Innovation was a critical aspect of ProVIC's FY2011 interventions, including:

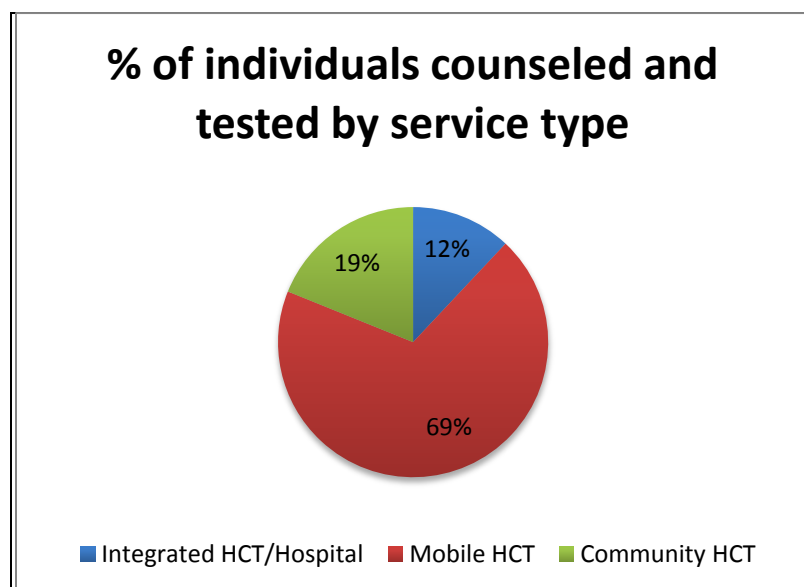
- Acquisition and utilization of modern mobile tents to serve as HCT sites.
- Initiation of “moonlight” (nighttime) HCT services to reach out to MARPs, particularly CSWs, where they live and operate.
- Introduction of the finger prick technique to reduce cost and improve efficiency.

**Table 3. ProVIC HCT sites by province.**

Province	Structure	Service type
Bas Congo	AMO-Congo	Mobile and community
	HGR Kiamvu	Integrated facility-based
	CSR Mvunzi	Integrated facility-based
	JADISIDA	Mobile
	HGR Kinzau-Mvute	Integrated facility-based
Katanga	AMO-Congo	Mobile and community
	AMO-Congo	Youth community
	AMO-Congo	Community
	World Production	Mobile and community
	HGR Kenya	Integrated facility-based
	HGR Panda	Integrated facility-based
	HGR Sendwe	Integrated facility-based
Kinshasa	Fondation Femme Plus	Mobile and community
	Progrès santé sans prix	Mobile and community
	Hôpital Marie Biamba Mutombo	Integrated facility-based
Sud Kivu	Fondation Femme Plus	Mobile and community
	Hôpital Général Nyantende	Integrated facility-based
	ACOSYF	Mobile
	ALUDROFE	Mobile
	HGR Bagira	Integrated facility-based

**CSR:** *Centre de Santé de Référence*; **HGR:** *Hôpital Général de Référence*.

**Figure 4. Distribution of individuals who received HCT services and received their test result, by type of HCT service.**



**Table 5. HIV seropositivity rate of individuals who received HCT and received their test result.**

Province	Percentage HIV positive	Number	Distribution HIV positive
Bas Congo	1.5%	484	10.2%
Katanga	5.4%	2,932	61.9%
Kinshasa	2.1%	1,104	23.3%
Sud Kivu	0.9%	214	4.5%
Total	2.9%	4,734	100%

HIV prevalence was abnormally high in Katanga compared to elsewhere. Katanga and Kinshasa released approximately 85 percent of new findings PLWHA.

### ***Opening of new HCT sites in Champion Communities***

Three new HCT sites were opened and integrated into health structures in Year 2 (see Table 4): *Hopital General de Reference* (HGR) Kinzau-Mvute, Bas Congo, HGR Sendwe in Lubumbashi, Katanga, and HGR Bagira in Bukavu, Sud Kivu. HGR Sendwe and HGR Bagira are the largest hospitals in their cities, and Sendwe is the second largest hospital in the DRC. The process began with a technical and managerial capacity assessment conducted by regional prevention and HCT specialists. Gaps identified were used to develop a tailored action plan with specific interventions aimed at bridging the gaps and improving the skills and knowledge of service providers. Each HGR's institutional capacity to provide HCT services was assessed and adequate equipment or infrastructure provided or recommended. Service providers in the three sites were trained and provided with capacity to provide high-quality HCT services in collaboration with the PNLs.

Quarterly formative supervision as well as regular technical coaching was provided to the new sites to bring them up to speed. They also received regular supplies of commodities, standardized tools, and small equipment to support delivery of HCT services.

**Table 6. New HCT sites by province.**

Province	Site	Type of HCT service
Bas Congo	HGR Kinzau-Mvute	DCIP
Katanga	HGR Sendwe	DCIP
Sud Kivu	HGR Bagira	DCIP

**DCIP:** dichlorophenolindophenol.

### ***Training of HCT service providers in family planning and gender-related issues***

A training needs assessment by regional prevention specialists is in progress in each HCT site. The sites with trained providers have received refresher training in family planning, and contraceptive commodities have been provided by USAID. Providers with no previous training in family planning have been trained in collaboration with the National Reproductive Health Program (PNR) and the PNLs.

Other achievements under this activity are the update and standardization of counseling and data collection and reporting tools, and revival of the national task force on family planning (PNSR, PNLS, United Nations Population Fund, United Nations Children's Fund [UNICEF], ProVIC, *Projet Intégré de Sante* [PROSANI], *Association du Bien-Etre Familial*, and others). ProVIC played a significant role in revitalizing the task force, which is led by PNSR.

### ***Ensuring procurement and distribution of HCT commodities***

Commodity management under ProVIC significantly improved in Year 2 due to a needs assessment, improved commodity projection and quantification of the program's needs by field office staff, identification and selection of qualified suppliers, effective planning of schedules for ordering commodities, and coordination between field office staff and PATH headquarters in Seattle, Washington. ProVIC hired an international consultant to develop a procurement and distribution plan as well as a local logistics officer to provide continuous control over ProVIC stocks. Two commodity orders were placed every six months in Year 2, with sufficient quantities for buffer stock. HCT sites were regularly supplied and commodity management tools were revised and standardized in collaboration with MSH/Strengthening Pharmaceutical Systems (SPS). Storage conditions were also improved thanks to onsite coaching of service providers and provincial officers in charge of commodities. Furthermore, a training module on commodity management was developed with technical support from MSH/SPS. The module will be used in Year 3 of the program.

### ***Integrating and managing HIV/tuberculosis co-infection through testing and referral***

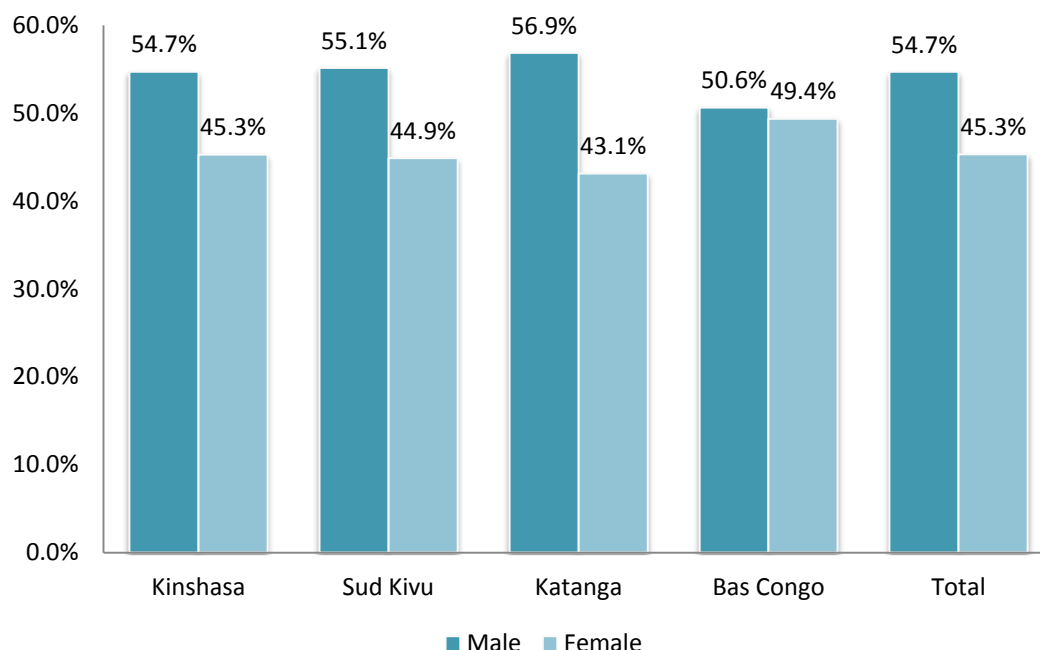
Two meetings were held between *Programme National de Tuberculose* and ProVIC's prevention and HCT team to establish coherent systems for referral and counter-referral for clients infected with both HIV and tuberculosis (TB). The meetings resulted in the mapping of sites providing TB screening and treatment and sites offering HCT services in Champion Communities. The referral and counter-referral systems will be consolidated in Year 3 with the technical support of the USAID-funded PATH TB Indefinite Quantity Contract Task Order 1 project. The existing tools will be harmonized and service providers trained in TB screening and HCT for effective management of HIV/TB co-infection.

In addition, the program will continue providing HCT services to TB-positive people who are members of *Clubs d'Amis de Damien* (Clubs Friends of Damien) in collaboration with TB screening and treatment centers. In turn, patients with HIV/TB co-infection will be referred to ProVIC HCT sites for psychosocial support.

### ***Improving the quality of services in HCT sites***

The ProVIC prevention and HCT specialists worked with HCT partners and the national HIV laboratory to establish a quality assurance system to ensure accuracy of results by sending random samples for verification both positive and negative samples. Technical assistance was provided to ensure the quality of blood samples, handling, storage, and transportation. Quarterly joint formative supervision was conducted by provincial HIV laboratory officers and ProVIC's prevention and HCT team to provide technical support and address any gaps identified throughout the process. Figure 4 shows the distribution of people who took the HIV test and received their results.

**Figure 7. Distribution by sex of individuals who received HCT and received their test result, by province.**



### ***Supervising prevention and HCT activities of implementing partners***

Quarterly and monthly joint supervision visits by the PNLS, PNMLS, and ProVIC were conducted in each province to assess the quality of HCT services, identify and correct gaps, and share HCT best practices and lessons learned. In addition, government counterparts supported and participated in the reinforcement of capacity of HCT providers, organized by ProVIC. Where possible, ProVIC conducted joint field activities with PSI/*Association de Santé Familiale* (ASF); PSI/ASF conducted community sensitization activities while ProVIC provided HCT services to MARPs and other at-risk groups.

### ***Challenges and proposed solutions***

- In the DRC, HIV testing of youth younger than 18 years requires parental approval. However, many youth are sexually active between 14 and 17 years old, including many CSWs, who are at high risk and are not likely to seek parental approval. ProVIC would like to make testing available to these youth, but risks legal issues if it does so. After the DRC elections in November 2011, ProVIC will explore the possibility of working through the national legislature to promote changes to this law.
- Follow-up on mobile individuals who test positive (truck drivers, CSWs) is a real challenge, as is providing follow-up activities for those who test negative. ProVIC would like to consider activities to help negatives remain negative, but resources are a constraint.
- Testing of CSWs in hotspots often involves security risks due to the nature of these neighborhoods and the late evenings during which the tests are conducted; therefore, ProVIC closes these operations earlier than ideal in terms of reaching the greatest number of individuals. At present, ProVIC closes its nighttime HCT around 11pm so that staff can

return home safely. The question is how to make the services available during expanded hours and also safe for staff to provide.

- In FY2011, ProVIC experienced stockouts of HIV tests and supplies, due in part to ProVIC's lack of capacity in supply chain management and partly due to the complexity of importation and distribution in the DRC. ProVIC hired a logistics officer and established a system to prevent stockouts, which have not occurred since July 2011.



**USAID**  
FROM THE AMERICAN PEOPLE

## Democratic Republic of Congo

# SUCCESS STORY

## Ambassador James F. Entwistle: ProVIC Community Champion

Improving access to HIV prevention services and reducing stigma through mobile voluntary counseling and testing



Photo Credit: ProVIC

*US Ambassador Entwistle and his wife look on as a health care worker draws his blood at a ProVIC mobile HIV testing unit in Bas-Congo.*

**As a Champion Community under the Integrated HIV/AIDS Project in the Democratic Republic of Congo (ProVIC), the people of Kinzau-Mvute are helping bring ProVIC's vision to life. In this and other targeted communities, ProVIC is using innovative approaches like mobile HIV counseling and testing (HCT) to bring services to the people who need them. Almost 70 percent of the 162,710 people tested by ProVIC during its second year were reached through mobile HCT services.**

June 2011 marked a historic moment for Kinzau-Mvute, home to about 18,000 people in the western province of Bas-Congo, when they received a visit from James F. Entwistle, United States Ambassador to the DRC, and his wife. They spent time touring ProVIC's activities and talking to community members—including most-at-risk populations like commercial sex workers, people living with HIV/AIDS, and orphans and vulnerable children—to learn about their experiences, perspectives, and needs. The Ambassador and his wife demonstrated the US Government's commitment to helping address one of the country's biggest health challenges.

Ambassador Entwistle and his wife also made headlines by joining in local celebrations to inaugurate ProVIC's new mobile HCT tents. Demonstrating their solidarity and support, they lined up for couples voluntary HIV counseling and testing (HCT) in front of the entire community. More than 170 couples, inspired by their example, lined up behind them.

The day was an empowering one for the people of Kinzau-Mvute: by helping reduce stigma around seeking HCT, the Ambassador and his wife helped fuel demand for these critical services in the community. The Ambassador's gesture also supported the need for increased male participation in critical activities in the fight against HIV/AIDS. ProVIC is addressing this need: in Year 2, 54 percent of all individuals tested for HIV were men.

In Bas-Congo, and in the three other project-supported provinces of Kinshasa, Katanga, and Sud Kivu, ProVIC is expanding and improving HCT services through mobile HCT units that circulate day and night to reach people vulnerable to HIV. The project is also reaching people through community-based HCT, and by integrating HCT into public and private health facilities.

Working with communities to strengthen their ability to develop and implement HIV prevention strategies is part of ProVIC's driving force: the Champion Community model. At the heart of this model is the need to actively engage individuals, families, and their communities to collectively define and resolve their own challenges—thereby taking ownership of their own futures. ProVIC works with local and international partners at numerous levels—from the community and facility levels to the regional, national, and international levels—to help communities find sustainable ways to actively participate in the fight against HIV/AIDS.

### **Sub-IR 1.3: PMTCT services improved**

#### ***Summary of activities and achievements in Year 2***

In FY2011, ProVIC was a PMTCT leader in the DRC both in terms of the capacity of its sites and via its leadership in advancing government policy. Most importantly, ProVIC was the first partner in the DRC to integrate the new WHO guidelines for PMTCT throughout all of its project sites. The new guidelines, while more complex and requiring additional logistical support and training, are an important step forward in that they can reduce the probability of transmission from mother to child to less than 2 percent, depending on adherence. Additionally, ProVIC technical assistance was at the center of USAID/DRC's planning for PMTCT acceleration, with ProVIC technical assistance providers assisting in the development of strategy, identification of sites, participation in training material redesign, and other essential steps in making PMTCT operational.

In total, ProVIC PMTCT sites provided HCT to 28,336 women in Year 2, including 483 individuals newly diagnosed HIV positive (see Table 5). Through ProVIC, 445 women received antiretroviral medications (ARVs) to prevent the transmission of HIV from mother to child, including 107 who received combination prophylaxis after ProVIC switched to this regimen in Q3. Of those, 34 were eligible for long-term antiretroviral therapy (ART) and will be transferred to Global Fund-supported sites when their coverage under ProVIC ends after 18 months post-birth.

**Table 8. Prevalence rate of HIV-positive pregnant women receiving PMTCT services.**

<b>Province</b>	<b>Pregnant women tested for HIV and received their result</b>	<b>Percentage newly identified positives</b>
Bas Congo	4,030	1.44%
Katanga	3,380	2.99%
Kinshasa	17,716	1.60%
Sud Kivu	3,210	1.25%
Total	28,336	1.70%

#### ***Strengthening the capacity of government to provide PMTCT services***

PMTCT assessment and continuum of care recommendations: During November 2010, Dr. Martha Mukaminega, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) Deputy Director for Pediatrics, conducted a short-term technical assistance (STTA) visit in collaboration with ProVIC technical officers Drs. Ditekemena and Katabuka. The purpose of the STTA was to assess PMTCT services (actual practices and availability) at ProVIC sites compared to international best practices in PMTCT, and to provide recommendations to address two of the highest-priority gaps in the continuum of care in the DRC. The gaps identified during the ProVIC project start-up in-country needs assessment were: identification of HIV-exposed infants and children, and linking exposed infants and their families from PMTCT services to care and treatment facilities.

The assessment found that sites that were effectively providing single-dose nevirapine prophylaxis were prepared to start providing PMTCT according to the new national guidelines.

Health facility staff reported being happy with the support they received from ProVIC, as did health authorities at the provincial and national levels. However, the lack of commodities (ARVs) to assist facilities in moving from single-dose nevirapine to combined regimens according to the new national and WHO guidelines was identified as a major gap, which has since been addressed by ProVIC's procurement of commodities for PMTCT.

The assessment highlighted an important gap related to the continuum of care for eligible pregnant women and their male partners: HIV-positive pregnant women who were clinically eligible for ART were not treated at PMTCT sites but referred for treatment. When referred, clients rarely showed up at an ART clinic. Assessment recommendations encouraged infant follow-up at each step in the maternal and child health care process, in order to maximize opportunities to keep clients and their children in care. This included the recommendation to develop and implement a joint mother-infant health card for use by health care sites that includes information about the mother-infant pair and helps connect the two. Based on these recommendations, the PMTCT specialist conducted discussions with the PNLs and PNSR about the feasibility of piloting this system at ProVIC PMTCT sites. Both groups received the recommendations with enthusiasm, and the team is currently developing the new health card. In the meantime, a symbol on the existing infant card is being used as a temporary measure to help trace exposed infants and keep them in the continuum of care system.

Provision of technical assistance to the PNLs at the national level to revise PMTCT and pediatric care training materials: During Year 1, the ProVIC PMTCT team led the revision of PMTCT and pediatric care guidelines according to the new WHO guidelines. During Year 2, Drs. Ditekemena and Katabuka assisted with updating the associated PMTCT and pediatric care training materials. The ProVIC team led technical experts at the national level through the process of updating the PMTCT and pediatric care components of the integrated training. Drs. Ditekemena and Katabuka developed culturally and contextually appropriate job aids related to PMTCT and pediatric care. The materials include a booklet for providers, which provides background on the new protocols, practical advice on early infant diagnosis and the use of cotrimoxazole in infants, and reference materials explaining the new guidelines, male involvement, and pediatric care. The doctors also developed practical advice based on first-hand experience with the issues that cause the most confusion and challenges for providers.

The PMTCT team participated and played a key role in the organization of the national PMTCT workshop held in Kinshasa in June 2011, which focused on brainstorming regarding HIV/AIDS elimination in the DRC. EGPAF sent two international experts at its own expense, and Dr. Ditekemena presented and moderated discussions during the workshop. Recommendations were given to introduce task-sharing and reinforce the PMTCT working group to develop innovative approaches to improve PMTCT coverage, including, for example, mobile PMTCT strategies.

In addition, in June, the ProVIC PMTCT team organized a briefing with the PNLs to introduce data collection tools to accompany the new PMTCT guidelines, such as a draft integrated antenatal care register that includes both mother and child health and PMTCT information, clinical forms for mothers and infants, and job aids for PMTCT providers. The tools were shared and discussed in a small group with the PNLs, PROSANI, and the ProVIC PMTCT team.

### ***Increasing promotion and uptake of pediatric counseling and testing and referrals for ART where services exist***

Referral of infected infants to treatment and placement of exposed infants on cotrimoxazole: The referral system implemented in Year 1 was reinforced using follow-up phone calls to mothers as well as to referral facilities. During Year 2, based on feedback from the treatment clinics, all HIV-infected infants were referred and showed up to treatment clinics. Of 187 polymerase chain reaction (PCR) tests for early infant diagnosis, 100 percent of infants were successfully referred (29 in Bas Congo, 15 in Katanga, 120 in Kinshasa, and 23 in Sud Kivu).

During this reporting period, ProVIC procured and made available (in January 2011) cotrimoxazole to prevent opportunistic infections in women and exposed infants. All of the PMTCT sites received cotrimoxazole for eligible mothers and exposed infants, although there have been challenges with uptake (see the “Challenges and proposed solutions” section below).

Tracking systems for mother-baby pairs lost to follow-up: The job aid providing practical advice regarding early infant diagnosis and follow-up was developed and shared with the providers at all 24 ProVIC-supported health facilities. The document gives instructions regarding infant follow-up and the use of additional strategies, such as phone calls and home visits, to track infants who are not presented for scheduled visits. As part of its package of site support, ProVIC has been providing phone credit for providers to facilitate the follow-up and tracking of clients who are lost to follow-up. In addition, the clinical forms detailed earlier for mothers and infants were developed to maximize the opportunity to trace infants and their mothers through routine maternal and child health services. These clinical forms and job aids were provided to all ProVIC PMTCT sites during the training conducted in Q3 2011 on the new national guidelines for PMTCT.

Follow-up system for mother-infant pairs: During the HIV integrated training in Q2, as well as WHO refresher training, draft mother-infant forms were shared with all ProVIC providers from all four provinces for feedback. The feedback was resoundingly enthusiastic. The initial response from the PNLS was equally enthusiastic. ProVIC was encouraged to develop the forms, which will fill a critical gap in the continuum of care for HIV-infected women and exposed infants.

Tracking system for HIV-positive women and their infants through maternal and child health services: To reduce loss to follow-up before the mother-infant card is introduced, the ProVIC PMTCT team advised providers to use a simple symbol on the mother and infant cards in order to help providers at under-five clinics trace exposed infants through maternal and child health services.

Reinforcing and troubleshooting the early infant diagnosis system: Thanks to the new tools developed by the PMTCT team, such as job aids and rapid advice documents related to early infant diagnosis and infant follow-up, the early infant diagnosis system was strengthened in this reporting period. The transportation and testing network throughout the different provinces where ProVIC is implementing PMTCT activities was also reinforced (e.g., through the introduction of DHL to courier samples and meetings with the national laboratory to ensure they were comfortable with using the system). Currently, other partners are asking ProVIC to join the network in order to implement early infant diagnosis. *Centre Regional d’Appui et de Formation*

*pour le Développement* in Bas Congo has already started sending samples via the network, and *Cliniques Universitaire de Kinshasa* in Kinshasa has verbally requested to join the network. A total of 187 exposed infants were tested at ProVIC sites in Year 2, and all 181 results were returned. Of those, 11 were HIV positive and the infants were referred to pediatric clinics for treatment.

***Providing technical assistance and capacity-building in PMTCT to MSH sites located in the geographic areas targeted by ProVIC***

Biweekly meetings with new national MSH project staff: During Q1 2011, AXxes PMTCT sites were transitioned from AXxes to PROSANI, as the AXxes program has been phased out. MSH/PROSANI has been enthusiastic about receiving ProVIC technical assistance on PMTCT and ProVIC. MSH agreed to hold biweekly technical meetings to allow regular follow-up on implementation of PMTCT activities, and it was decided that ProVIC will continue to provide technical assistance on PMTCT. The technical team shared documents related to technical assistance provided to AXxes by ProVIC last year and determined the important areas of assistance as suggested by the needs assessment. Dr. Ditekemena helped PROSANI develop a needs assessment that was conducted in Q2 and Q3. Dr. Katabuka provided technical assistance to the PROSANI HIV team on how to effectively introduce and implement early infant diagnosis. All technical documents developed by the ProVIC PMTCT team for ProVIC use were shared with the PROSANI HIV team. This collaboration shows the synergies that can be achieved through interactions between United States government-funded programs.

The ProVIC PMTCT team provided tailored technical assistance to PROSANI based on the results of the needs assessment conducted at all PMTCT sites. Drs. Ditekemena and Katabuka provided support during the implementation of the needs assessment. Dr. Katabuka traveled with PROSANI HIV officer Dr. Raoul Ngoy to Katanga in May to conduct the needs assessment. Due to a delay in return of the forms from the provinces, data analysis is currently underway and the report will be finalized shortly.

The ProVIC PMTCT team used the needs assessment as an opportunity to conduct joint supervision visits with the PROSANI team in Katanga to improve the quality of PMTCT delivery. Drs. Katabuka and Ngoy and provincial prevention specialist Dr. Lydia Shabanza conducted joint supervision visits in Katanga. Another joint supervision visit was conducted in Sud Kivu in June and July by Dr. Katabuka, Dr. Astrid Mulenga (ProVIC provincial prevention specialist), and PROSANI Bukavu PMTCT specialist Mr. Thierry Kasende Okoko.

Memorandum of understanding with MSH on technical assistance and collaboration: In Year 2, the ProVIC and PROSANI teams worked to harmonize all areas of collaboration. A memorandum of understanding outlining areas of collaboration and coordination was finalized in Q4. The final version has been accepted by both parties and is expected to be signed in Q4.

***Increasing uptake of comprehensive PMTCT services and referral of pregnant women eligible for ART services***

Onsite training on the new PMTCT and pediatric care guidelines: In June and July 2011, the ProVIC PMTCT team conducted refresher trainings on the new PMTCT guidelines for 160 providers in Bas Congo, Katanga, Kinshasa, and Sud Kivu. Updated tools and job aids were

shared with providers during these training sessions. In Q3, after the refresher trainings, ProVIC provincial teams distributed ARVs to all the ProVIC PMTCT sites as part of the implementation of the new PMTCT guidelines.

Management of medical waste in ProVIC PMTCT sites: When incinerators were renovated in Matadi and Katanga in Q1, the ProVIC team took the opportunity to reinforce medical waste management. The regional prevention specialists along with the PMTCT and pediatric specialists conducted several supervision visits at ProVIC PMTCT sites to verify that medical waste was being appropriately managed. ProVIC has since developed an integrated supervision tool that includes a medical waste management component, as well as information regarding PMTCT, HCT, and care and support for patients. The tool has been used at the provincial level to ensure that medical waste is well managed at all ProVIC PMTCT sites.

During Year 2, the ProVIC PMTCT team developed a simple, one-page PMTCT provider-initiated counseling and testing monitoring tool tailored to help track mother-infant pairs throughout maternal and child health services (e.g., labor, under-five clinic, family planning, and postpartum). The tool was shared during refresher training with all providers in the ProVIC PMTCT sites.

### ***Improving access to comprehensive PMTCT services***

During supportive supervision visits to the PMTCT sites, the supervisors (PMTCT, pediatric, and provincial prevention specialists) provided technical assistance to providers to reinforce the linkages between PMTCT activities and family planning as well as other maternal and child health services. Where family planning services are not yet implemented, the providers were encouraged to organize the referrals for pregnant women in need. The providers at Catholic health facilities were also encouraged to refer clients to the closest facility where family planning services are available. The referral sites were identified in collaboration with the health zone teams and the faith-based sites.

During Q4, ProVIC received family planning commodities from USAID and is planning a training for all the providers prior to distribution to ProVIC PMTCT sites across the DRC.

### ***Challenges and proposed solutions***

- Delays by granting partners and suspension of direct support to sites: Due to the suspension of direct support to sites in Q1, some activities could not be completed as planned. For example, the number of home visits to trace mother-infant pairs decreased, which impacted the achievement of some results, like reaching the target number of exposed infants presented at facilities for early infant diagnosis, as well as for those who should present to receive cotrimoxazole prophylaxis. However, under the new fixed obligation grants developed for all private facilities and approved by USAID, activities should resume. Public facilities will operate under collaboration agreements, which will allow for the continuation of direct support for critical inputs such as ARVs, cotrimoxazole, CD4 analysis, prepaid phone cards for calling clients lost to follow-up, and transportation fees for home visits. In the mean time, facilities are supported by direct support.

- Lack of CD4 analysis and ARV provision for HIV-positive male partners of HIV-positive pregnant women: Because of resource limitations, CD4 testing and ART was planned only for pregnant women and their infants and did not include HIV-positive male partners. Eligible male partners should be referred elsewhere for care and ART; however, these referrals are frequently unsuccessful. In order to increase the effectiveness of the PMTCT program, based on suggestions received from clients, it would be better to start basic care at the PMTCT venue for eligible male partners as well as women and infants, and then transfer the HIV-positive males to HIV outpatient clinics.
- Lack of support to carry out hemoglobin analysis for poor women: Baseline hemoglobin analysis is very important for all HIV-positive pregnant women prior to starting either azidothymidine (AZT) prophylaxis or an AZT-based regimen, as evidence shows that AZT is associated with anemia.
- Lack of provision for additional laboratory analysis for eligible pregnant women in need of targeted analysis, such as liver and kidney function: Some ProVIC clients present in an advanced stage of AIDS. These clients require additional clinical tests for high-quality care and treatment, such as liver and kidney function analysis. It is important to have the results from these analyses to inform patient treatment toward helping to prevent liver and kidney failure. Within the current system, these analyses are not free of charge, and most ProVIC patients are poor, so few opt for fee-based testing.
- Difficulty providing continued care for HIV-positive children detected early: Most pediatric facilities are located far from ProVIC PMTCT facilities; therefore, families of infected infants identified at ProVIC PMTCT sites are required to travel a great distance to attend a pediatric clinic. The ProVIC PMTCT team has developed a strong mechanism for referrals where a health provider accompanies the child, but the major barrier to its success is the distance between PMTCT sites and pediatric clinics. It is recommended that ProVIC provide transportation fees to caregivers of infected infants to help them present on time at pediatric facilities.

In addition, the proportion of exposed infants returned for their second and third PCR tests (at nine and 15 months, respectively) is very low. This may require strengthening of the messages to mothers to return for subsequent tests. ProVIC is focusing on this issue in the Champion Communities, at facilities during antenatal care, delivery, and postpartum to reinforce messages regarding the importance of infant PCR testing. ProVIC also plans to create handouts and pamphlets in collaboration with C-change to address this issue.

ProVIC procured cotrimoxazole to prevent opportunistic infections in women and exposed infants but had difficulty with uptake. Eligible mothers and infants who presented at six weeks postpartum could receive cotrimoxazole for prophylaxis, but only 75 of the 187 exposed infants received the drug within two months of birth during the reporting period: eight in Bas Congo, seven in Sud Kivu, nine in Katanga, and 591 in Kinshasa. This was due in part to the fact that cotrimoxazole only became available in mid-Year 2.

- Low male involvement and lack of CD4 analysis and ARV provision for male partners at identification: To address this, ProVIC intends to promote male involvement through male Community Champions. Further, it is expected that additional PIMA mobile CD4 equipment will be available through the PEPFAR PMTCT Acceleration Plan.

- Lack of capacity to perform additional laboratory analysis, such as for liver and kidney function: It is hoped that the procurement for the PMTCT acceleration will include equipment for analysis of liver and kidney function.
- Most pediatric facilities are located far from ProVIC PMTCT facilities, posing difficulties in providing continued care for HIV-positive children detected early. ProVIC does not have a solution for the ongoing problem of access to services in the DRC.

## **Intermediate Result 2: Care, support, and treatment for people living with HIV/AIDS and orphans and vulnerable children improved in target areas**

### **Summary of activities and achievements in Year 2**

In Year 2, subsequent to the establishment of Champion Communities, ProVIC grantees were able to greatly expand care and support activities, and by the end of the period, 20,310 PLWHA and OVC had received a minimum of one care service (see Table 6). Of those, 8,638 received at least one clinical service and 8,206 received cotrimoxazole. Further, 8,536 individuals received food and nutrition services and 1,257 clinically malnourished individuals received therapeutic or supplementary food.

ProVIC's care and support activities increased significantly in Year 2 as the full strategy of empowering individuals and communities to care for themselves was rolled out step-by-step after intensive training of community members. Key factors of the increase and in the establishment of the system included (1) establishment of 149 self-help groups and 94 child-to-child (C2C) groups; (2) 5,000 home-based visits; (3) provision of targeted support based on vulnerability criteria; (4) effective involvement of the care and support team, technical support, and quality assurance; (5) guidance from potential partners such as the Food and Nutrition Technical Assistance Project/Livelihood and Food Security Technical Assistance Project (FANTA/LIFT). This combination of interventions ensured a better understanding of the ProVIC care and support strategy, and enabled the project to effectively reach PLWHA and OVC and their families. ProVIC anticipates great improvements in quality in FY2012 and will expand the self-help group strategy, the C2C approach, and home-based visits. ProVIC will also integrate a number of recommendations from USAID (regarding the various definitions of vulnerability), FANTA/LIFT (improved linkages between curative and preventative nutrition and promotion of individual income-generating activities [IGAs]) and UNICEF (effective implementation of the block grant strategy to enable OVC to go to school). ProVIC will also focus on becoming sustainable by ensuring the greater involvement of Champion Community steering committees and their ownership of the project's interventions.

## Sub-IR 2.1: Care and support for PLWHA strengthened

### *Developing a toolkit on positive living, positive prevention, and palliative care*



*The care and support team with BAK-Congo OVC in Kasumbalesa in fall 2011.*

An essential step in establishing ProVIC's care and support model was the development of a care and support toolkit on positive living, positive prevention, and palliative care, to ensure that the ProVIC approach is consistently applied across ProVIC provinces, partners, and communities. The toolkit uses participatory exercises to address issues related to positive living, positive prevention, and palliative care. The five key principles of positive living included in the toolkit are gender, empowerment, ethics, participation, and support. The positive prevention component includes many

key PEPFAR themes: sexual behavior change; sexual and reproductive health, including STI prevention; HIV/TB co-infection; opportunistic infections; HCT; HIV status-sharing; ethics and confidentiality; impact on children/family planning; and alcohol and drugs. The palliative care capacity-building component focuses on symptom management, pain relief, home- and clinic-based care, community mobilization, and participation in palliative care through advocacy and social campaigning.

### *Capacity-building of service providers in positive living, positive prevention, and palliative care*

Once the toolkit was developed, the critical first step in getting actual services to beneficiaries at the community level was the training of community service providers linked to Champion Communities. Through a national workshop and provincial workshops, ProVIC trained 30 trainers at the national level and 86 at the provincial level. MINAS, DIVAS, and PNMLS also participated in the training. The trained service providers were instrumental in setting up self-help groups and holding regular meetings, during which positive prevention issues were discussed in depth. The provision of regular refresher trainings will ensure the quality of self-help group meetings and the transfer of skills and knowledge to PLWHA in the medium to long term to enable them to attend thematic meetings themselves.



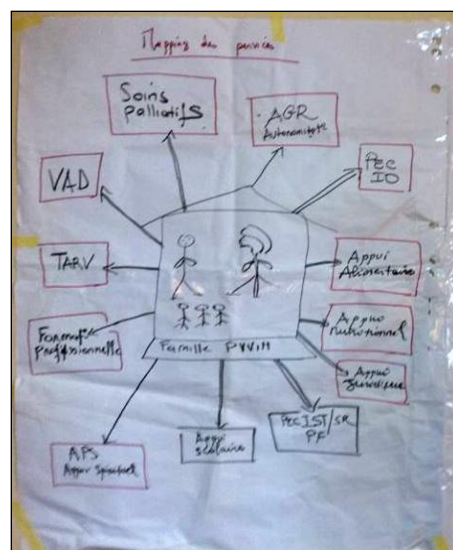
*The Deputy Chief of Party posing with participants and facilitators.*

Trained providers will be involved in supporting and supervising PLWHA, and ensuring the quality of self-help group meetings.

### ***Training on how to use mapping and audit tools for PLWHA services***

While the training of the community was an essential step, so too was the training of ProVIC and government staff who will oversee and supervise the program in the use of mapping and audit tools. The ProVIC care and support team received technical support from international consultant Demba Diack for the development of the mapping and audit tools for PLWHA services. This was followed by field-testing, during which the tools were used at the local level with PLWHA, grantees, health authorities, and other decision-makers involved in the local response to HIV in Bas Congo, including the Medecin Inspecteur Provincial, the Medecin Chef Zone in Nzanza, the Medecins Chefs Districts in Matadi, the doctor in charge of the HGR in Mvuzi, PNMLS and PNLs officials, and MINAS/DIVAS.

This exercise highlighted gaps in services available to PLWHA and enabled the realignment of ProVIC interventions to help improve their quality of life. PLWHA were able to identify their most pressing needs: supporting the education of OVC, individual or collective IGAs, treatment for opportunistic infections, CD4 counts and biological follow-up, nutritional support and advice, and training of PLWHA to provide home-based palliative care. In Year 3, the auditing tool will be cascaded down to the support groups to enable them to independently assess the quality of services provided. They will be able to gather evidence to help them in their discussions with decision-makers, with a view to influencing HIV policy and programming.



*Notes from a focus group discussion on mapping and quality control using a family-centered approach.*

The Matadi mapping and audit exercise produced the following recommendations:

- Accelerate the support provided to partner organizations in order to implement care and support activities for PLWHA.
- Strengthen the organizational capacities of partner organizations. The successful implementation of these two recommendations should be the focus of Year 3, and will require tailored one-on-one support in each province in order to ensure the best results possible.

In practical terms, this means:

- Concentrating on priority needs identified by PLWHA: economic support via IGAs, nutritional support and education, OVC support, treatment of opportunistic infections, follow-up of patients to address psychosocial support issues, and referral for physical ailments.
- Intensifying anti-stigma and discrimination strategies for PLWHA and their families.

- Supporting the development of strategies to help integrate treatment adherence within health-care settings (community-based organizations and public health centers).
- Implementing a capacity-building mechanism for public health providers to ensure the quality of care provided to patients (e.g., facilitation of clinical staff meetings and quality circles).
- Supporting the creation of collaborative links between community-based organizations and health care providers via the establishment of cooperation agreements.
- Supporting health authorities to better coordinate follow-up, supervision, and monitoring activities.

### ***Self-help groups: positive prevention, positive living, and palliative care***

Self-help groups are a cornerstone of ProVIC's community-based and sustainable approach to providing services for PLWHA. The groups are composed of 25 people each who have agreed to disclose their status and share their stories. Members of the groups help each other analyze their problems and take appropriate action, and the groups provide an organized structure



*Dr. Alexandre, South Kivu Care and Support Manager, supervising an ALUDROFE PLWHA group in the Champion Community of Kabimba.*

around which ProVIC can offer services such as psychosocial support and clinical and nutrition counseling. Self-help groups build solidarity among members, help them take control of their lives, develop individual courage to face stigma and discrimination, and offer opportunities for members to learn about different issues.

By the end of August 2011, ProVIC grantees had set up 149 self-help groups and organized regular thematic meetings. These groups are operational in 40 Champion Communities and are an ideal mechanism through which to provide a variety of services to PLWHA and discuss issues related to positive prevention, positive living, and palliative care. They also help build and strengthen links between PLWHA, enabling them to share their experiences and become empowered.

To ensure the success and quality of self-help group meetings, a number of visits were carried out in the four provinces in the following Champion Communities: Bagira, Igoki, Kabimba, Kalundu, Nyamugo, and Nyantende, Sud Kivu province; Kinzau-Mvuete, Nsakala-Nsimba, and Mvuzi in Bas Congo; Kasumbalesa, Kolwezi, and Lubumbashi in Katanga province; and Biyela, Kikini, and Masina I and II in Kinshasa. ProVIC worked with grantees to improve the planning of thematic meetings, ensure the meaningful participation of PLWHA during the meetings, clarify the organizational structure and facilitation of group meetings, and provide feedback to facilitators, particularly with regard to the use of key facilitation techniques (creating an environment conducive to learning, initiating discussions, reformulating ideas, synthesizing,

paraphrasing, using life stories and role plays, etc.). Self-groups have become a key psychosocial care and support strategy for PLWHA because of the quality of the discussions, the variety of issues raised, and the level of PLWHA participation.

### ***Home-based visits***

Grantees in the 40 Champion Communities carried out more than 5,300 home-based visits throughout the year, via social workers and community volunteers. These targeted home visits were scheduled on the basis on PLWHA membership cards. Through the use of a family-centered approach, workers and volunteers were able to reach PLWHA family members and identify patients lost to follow-up; and provide psychosocial, bereavement, and spiritual support to patients and families, mediation within families, home-based care to ill patients, and nutritional support. The visits were also a way of teaching families how to dispose of biomedical waste.

Through this multifaceted approach, home-based visits have also become a key strategy that will need to be consolidated, strengthened, and scaled up.



*Dr. Clémence Mitongo, home-based palliative care manager, and Dr. Babeth Katumbo, Lubumbashi care and support manager, supervising the establishment of 'La Kenya' group with AMO-Congo.*

### ***Promoting the law designed to protect the rights of people living with and/or affected by HIV/AIDS***

Following the unilateral commitment made by 182 heads of state and government during the United Nations Extraordinary General Assembly on HIV/AIDS, the DRC voted and promulgated the law on HIV-related human rights for people living with and/or affected by HIV/AIDS (Law No. 08/011, July 14, 2008). Nonetheless, the law remains largely unknown to the general public and to those directly concerned, making it difficult to implement.

For this reason, ProVIC organized forum meetings during World AIDS Day 2010 to raise awareness of PLWHA and affected people, as well as the general population. In December 2010, ProVIC organized four forums, in Bas Congo, Katanga, Kinshasa, and Sud Kivu. The forums had two main objectives: (1) encourage communities to talk about the protection of PLWHA/OVC and their families, and (2) distribute copies of the law to a large and diverse audience to improve knowledge and encourage respect for the law.



*Katanga forum: Strong community mobilization around HIV-related rights.*

The forums reached 675 PLWHA, affected people, and community members in Bas Congo; 467 PLWHA and affected people in Katanga; 36 PLWHA organizations in Kinshasa; and 758 PLWHA and OVC in Sud Kivu.

In addition to the forums, self-help groups and home-based visits were used as opportunities to talk about the law, thereby reaching an additional 4,400 people living with and/or affected by HIV/AIDS.

### ***Providing cotrimoxazole to PLWHA***

Opportunistic infections accelerate the progression of HIV and increase morbidity and mortality rates. To reverse the negative effect of opportunistic infections on PLWHA, ProVIC supported grantees to provide cotrimoxazole, beginning in February 2011. The ProVIC national coordinator and HCT/prevention manager carried out a needs assessment, and grantees distributed cotrimoxazole during medical visits and self-help group meetings. During home-based visits, cotrimoxazole was given only to PLWHA who had disclosed their status so as to protect those who had not yet done so. Beneficiaries signed distribution forms, thus enabling accurate data collection for this activity.

### ***Nutritional support***

It is well documented that the energy requirements of PLWHA are higher than for those who are well. Ill health can lead to poor appetite or rapid weight loss and lowered immune levels. Within this context, nutritional support is a useful strategy to include in care and support programs, while more sustainable community-based alternatives are developed to empower PLWHA to support themselves. Nutritional support contributes to improving patients' reaction to their HIV treatment by maintaining their weight and physical strength. This in turn delays the virus' progression and helps PLWHA remain active and look after their families. Grantees explored a number of options to provide nutritional support to PLWHA. Three of these options stood out from the rest: (1) the distribution of nutrition kits to the poorest PLWHA and households; (2) community meals to be organized during self-help meetings; and (3) empowerment of PLWHA through agro-pastoral activities and other income-generating projects.

Nutrition kits varied from one province to the next, but all contained the following elements: protein, carbohydrates, vitamins, and vegetable oil. An example of a nutrition kit: corn flour, rice, palm oil/groundnut oil, salt, sugar, and beans.



*Distribution of nutrition kits to PLWHA and OVC with AMO-Congo, Lubumbashi.*

The nutritional support provided to PLWHA varied according to the clinical classification of their malnutrition. The grantees appointed nutritionists to assess PLWHA by weighing and measuring them during medical consultations. They were then able to identify severe, moderate, and low levels of malnutrition and categorize each patient accordingly.

Overall, beneficiaries welcomed the nutritional support provided. However, near the end of FY2011, USAID-supported technical assistance providers from FANTA/LIFT made recommendations regarding the integration of curative and preventative strategies that will be implemented in Champion Communities in Year 3. Arm circumference measurement equipment will have to be purchased and given to grantees. In addition, patients suffering from severe malnutrition will have to be hospitalized and ProVIC will need to provide specific nutrition kits for moderate and severe malnutrition cases.

### ***Income-generating activities***

ProVIC's NGO grantees developed a number of income-generating activities in the four provinces to increase the project's sustainability and empower PLWHA to become financially independent. The beneficiaries carried out market analysis exercises and received training on management of IGAs from grantee resource persons. Through the grantees, ProVIC also funded the self-help groups to organize collective IGAs. The reimbursement of loans will be used to fund other IGAs, thereby enabling a greater number of PLWHA to become independent.

### ***Challenges and proposed solutions***

- Delays in establishing the grants contributed to the late start of the care and support activities and explains the poor performance in the first quarter of 2011. Grants are now fully in place and systematic, so this problem is behind us.
- Individual medical and social files were developed in Year 2 to capture essential and nondiscriminatory information about project beneficiaries, but ProVIC lacks a database to capture information on PLWHA supported by the program. Development of an effective database will help ProVIC access information at any time, and shape our future activities.

The ProVIC database is presently reaching final development and will improve the capture of individual patient information.

- Not all of the people trained in positive living, positive prevention, and palliative care were effectively involved in implementing self-help group activities. Training Champion Community members, including PLWHA, in facilitation and management techniques should resolve this issue. The care and support team will also carry out regular supervision visits for quality control purposes.
- We were unable to finalize the positive living, positive prevention, and palliative care messages for self-help groups to ensure the consistency of information given to PLWHA. A local consultant and additional work with C-Change will support the technical team in finalizing the work.
- Caregivers will be trained to provide home-based palliative care services. A local consultant will help refine the strategy and develop a checklist. In addition, a palliative care kit will be assembled and given to grantees.
- The budget for the care and support component is limited, which means that ProVIC is unable to cover all of the PEPFAR indicators to their standards or national standards. For example, nutritional support should be provided four times (or more), but ProVIC was able to provide it only once. To address this, the project is moving toward a more preventative approach to nutritional support so that ProVIC beneficiaries will not be dependent on ProVIC food distribution.
- The nutrition support kits did not take into account the results of the clinical malnutrition diagnoses. The finalization of the nutritional support protocol for PLWHA with PRONAUT should help us to solve this problem.
- ProVIC lacks tools for the implementation of sustainable IGAs. LIFT will help the project to develop sustainability mechanisms for IGAs in 2012.

## **Success stories**

### **Bas Congo**

- ❖ AMO-Congo developed a collective microcredit-based IGA (cassava mill).
- ❖ JADISIDA started a beauty therapy workshop for OVC, also using microcredit.

### **Katanga**

- ❖ BAK-Congo supported individual IGAs by providing small loans to PLWHA to help them increase their capital. A number of beneficiaries were trained and developed poultry farming businesses.
- ❖ World Production developed a collective IGA: small business development (a kiosk selling a variety of small items), with 10 percent of the profits reinvested in other IGAs in the form of microcredit loans.
- ❖ OLASEC developed a collective market garden IGA of cabbages for sale.

### **Kinshasa**

- ❖ SWAA developed individual IGAs: groundnut, marrow, and wangila mixer; handbag-making; and travel bags made from bags of rice, which can be sold within the city and abroad.
- ❖ PSSP developed a collective IGA by purchasing a large machine to grind corn and cassava. The dividends from this activity will help fund individual IGAs through microcredit loans.
- ❖ AMO-Congo developed two collective IGAs: purchasing an oil-fired machine to grind corn and cassava, and selling plastic items (tables, chairs, basins, etc.). The dividends will be invested in individual IGAs.

### **Sud Kivu**

- ❖ ALUDROFE developed a collective IGA: a community smallholding growing cassava and groundnuts. Part of the harvest is distributed to PLWHA and OVC, and the other part is sold. ALUDROFE also purchased an oil-fired mill to grind cassava. The profits are deposited into a savings account that will help fund individual IGAs and ensure sustainability.
- ❖ ACOSYF developed collective IGAs: goat-rearing and setting up a print shop.



**USAID**  
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## Democratic Republic of Congo

# SUCCESS STORY

## Elizabeth Kimpuny: a Community Champion in Biyela, Kinshasa

Community leadership fosters behavior change around HIV/AIDS and mobilizes communities



Photo Credit: ProVIC

*Ms. Kimpuny distributes school kits to two children as their grandmother looks on. OVC support activities like these are part of Champion Community outreach efforts organized by The Society of Women Against AIDS in Africa, a local nongovernmental organization partnering with ProVIC.*

**Just six months after implementation of the Champion Community approach in the Democratic Republic of Congo (DRC), participating communities are noticing positive results. Community ownership of this approach is stimulating a culture of self-reliance and engagement in resolving issues related to HIV/AIDS that affect communities and their members. This approach is part of the *Projet Intégré de VIH/SIDA au Congo* (ProVIC), or the DRC Integrated HIV/AIDS Project.**

In the Champion Community of Biyela, Kinshasa, Ms. Elizabeth Kimpuny, a steering committee member, goes door to door each week to contact people living with HIV/AIDS (PLWHA), orphans and vulnerable children (OVC), widows, and other affected families. She refers people needing care, treatment, and support to appropriate service delivery points and facilitates access to services. Elizabeth has earned the respect of community members and community workers, who see her as a role model and a leader.

During one of her visits, Elizabeth met an 80-year-old woman who had lost custody of her five grandchildren ranging from 8 to 14 years old. Accused of sorcery by other family members upon the death of their parents from HIV/AIDS, the children had been taken to a church for spiritual cleansing.

Moved by the children's plight and separation from their family, Elizabeth mobilized church and community leaders, local administrative authorities, grassroots organizations, and community workers to recover them. Now reunited with their grandmother, the children enjoy a stable and peaceful life. They attend Luizi primary school, and through ProVIC, receive nutritional support, community protection, and health care.

Elizabeth later visited the children again, this time with school kits in hand. Touched by Elizabeth's continued care and follow-up, their grandmother thanked her and ProVIC for making it possible for her grandchildren to go to school and become productive citizens.

By mobilizing others in her community, ProVIC Community Champion Elizabeth Kimpuny helped change the local pastor's view of children orphaned by HIV/AIDS as sorcerers. Not only did he adopt more protective behaviors toward these children through Elizabeth's efforts, but he has also since reached out to his colleagues to advocate for reintegrating other orphans with their extended families. Interventions like this one in Biyela, and in other ProVIC Champion Communities in Kinshasa, Matadi, Bas-Congo, and Sud Kivu, are raising awareness about discrimination against PLWHA and OVC and stimulating positive behavior change among individuals, their families, and their communities in the fight against HIV/AIDS.

## Success stories

One of the program's major successes and areas of innovation across the four provinces in Year 2 was the creation of new self-help groups and the revitalization of old ones. These groups helped us to provide a variety of services to PLWHA and to boost our results within a short period of time. Further, each province has its own success stories:

### Katanga

- ❖ OLASEC supported Mapendo, a self-help group of women living with HIV, with funds to start an IGA. The group used the funds for market gardening. The group purchased watering cans, seeds, and fertilizer, and worked the land and had a healthy harvest. They were able to pay for their children's school fees.

### Kinshasa

- ❖ A PLWHA self-help group in the Champion Community of Biyela became a community solidarity group, which was able to give out grants for individual IGAs to PLWHA and OVC targeted by SWAA. Women living with HIV purchased mills to grind groundnuts and were able to generate between 40,000 and 60,000 Franc Congolais a month.
- ❖ Women living with HIV from SWAA learned how to weave travel bags made of empty rice bags from the nutritional support activity. The bags were sold locally and throughout the region for \$20. The women also made school bags, which were given to OVC as part of the educational support intervention.

### Sud Kivu

- ❖ In the Champion Community of Kabimba, the PLWHA support group developed a community field of groundnuts and cassava. This activity complemented the nutritional support component, as some of the harvest was given to beneficiaries, while the rest was sold and the dividends reinvested.
- ❖ Health care service providers regularly took part in PLWHA self-help group meetings, and PSI/ASF participated in self-help group meetings to discuss issues related to family planning and strengthening linkages between community-based structures and health care agencies.

## Sub-IR 2.2: Care and support for OVC strengthened

### *Mapping and OVC services audit*

In order to better assess and monitor OVC interventions, the ProVIC care and support team received training in mapping and quality control techniques (auditing) for OVC services in Katanga in February 2011. The objective was to take stock of the various HIV/AIDS services for OVC in the four provinces where ProVIC is operational and make recommendations to help ProVIC develop its future interventions for OVC and families. The PNLS, PNMLS, DIVAS, OVC and their families, community

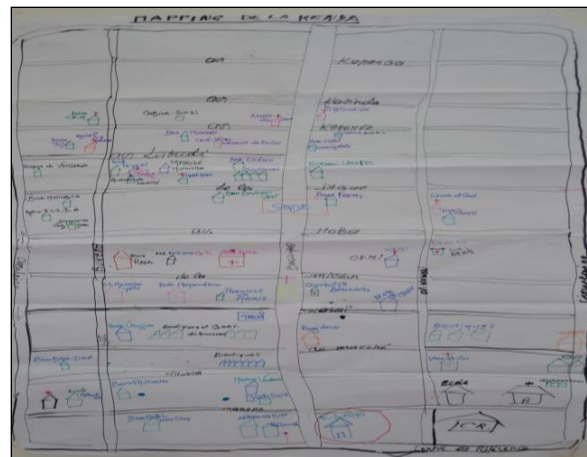


*An OVC participates in a mapping exercise using the CSI in Kasumbalesa.*

leaders, tutors, HIV-positive women and men, school head teachers, and a few Champion Community members were involved.

The exercise highlighted the following:

- Beneficiary satisfaction and the impact of services on their lives: quality, accessibility, distance to services, opening hours.
- Needs yet to be met.
- OVC participation at all stages of the program.
- The OVC situation in the intervention zone.
- The ability to discuss problems with others (adults/children/friends).
- Family and community participation at all stages of the program.
- Program sustainability and survival.



*Mapping carried out by OVC from 'La Kenya' using the Child Status Index in Kasumbalesa.*

The Child Status Index was used with OVC and provided the following information:

- Food and nutrition: social security, nutrition, and development.
- Shelter and guardianship.
- Protection: abuse, exploitation, and legal protection.
- Health: well-being and medical care.
- Psychosocial: emotional state and social behavior.
- Education and capacities: school performance, education, and work.

OVC were categorized according to their degree of vulnerability (highly/mildly/not vulnerable).

The mapping and audit exercise highlighted a number of problems, including:

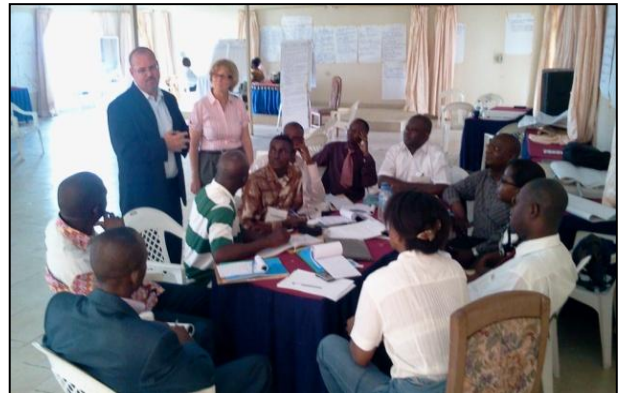
- Food security: In general, OVC eat only once a day, depending on their mother's or caregiver's capacity to find food. Their food intake is not varied and consists mainly of rice,

beans, and horse mackerel. This does not mean that different types of food are not available in the region, but that they do not have access to it.

- There seems to be a lack of dialogue/emotional connection between OVC and their caregivers.
- Most OVC live in overcrowded homes, often sharing a mat with two or three others or sleeping on the floor in a clay hut. Their accommodations are humid and they do not have access to running water or toilets.
- The majority of OVC have no legal protection (e.g., no birth certificates and lack of respect for children's rights, etc.).
- Most OVC do not have access to medical care due to their financial circumstances. Host families and caregivers tend to self-medicate and use traditional healers.
- Some OVC have given up hope and no longer enjoy life; they do not think of their future, and lack any affection or moral comfort.
- Most OVC perform quite well in school. They are often among the top in their class. This result is in stark contrast with the difficulties they must overcome to get to school, including distance, fear of exclusion for not paying school fees, and hunger.

### ***Training of trainers workshop on the C2C approach***

C2C is a health education approach that was developed by Professor David Morley. Based on cooperation between the health and education sectors, it encourages active child participation in health promotion and community development. It supports them to find solutions to common problems in six stages: (1) identify a problem within the community, (2) analyze the problem to identify its causes and consequences, (3) discuss possible solutions, (4) decide what simple but effective actions can be taken, (5) develop an action plan, and (6) implement and evaluate the action plan. This method can be used in schools, health centers, churches, and formal and informal youth groups. It focuses on the promotion of children's well-being by allowing each child to think about his/her situation and to actively engage in finding ways to improve it.



*ProVIC's Chief of Party participating in the C2C TOT.*

In Year 2, ProVIC assigned an international consultant to roll out the use of the C2C approach in four stages: (1) a five-day TOT workshop for C2C group facilitators, (2) a two-day practical exercise with children from the Mater Dei primary school, (3) finalization of action plans for each province, and (4) implementation.

### ***Establishing C2C groups***

Before establishing the C2C groups, training needed to be cascaded from the TOT down to the community level. In the first training, 30 trainers of service providers were trained in facilitating



*Children performing a role play with a C2C group in Katanga.*

groups of children using the C2C methodology. Following the C2C training, each province developed an implementation plan. The target was establishment of 25 groups of children to meet and discuss their problems together, under the supervision of a trained facilitator.

Since June 2011, 94 C2C groups have become operational in the four provinces. Each group of children leads its own investigations, offers solutions, and develops action plans through the use of role plays, simulation exercises, songs, dances, etc. The children have welcomed this strategy, as it helps them to discover their own capabilities and to ask adults to make changes that

can improve child well-being. The C2C groups also allow ProVIC to target various services to OVC, such as nutritional support, provision of food supplies, and medical consultations.

Among the issues most often identified by children include difficult access to drinking water, high levels of malaria, nonpayment of school fees, child safety, and lack of play space and appropriate hobbies for OVC. The children prioritized the topics and proposed a variety of solutions that have generated impressive results. For example, different groups have run successful advocacy campaigns targeting parents and children to purify water and



*TIFIE using the C2C approach at the Kimbondo children's hospital.*

encourage handwashing to avoid water-borne diseases, and to use treated mosquito nets. They have lobbied parents/caregivers to pay school fees or ask other community members to provide block grants to schools to cover fees. They have also targeted local authorities to ask them to close local cinemas showing pornographic films that encourage risky sexual behaviors. One community asked that girls be relieved of the duty of collecting water from distant water sources to avoid the possibility of being attacked.

These initiatives have had a real impact on communities; children now feel useful and listened to when it comes to decisions that affect the community as a whole.

The C2C approach is useful for involving children in the identification and resolution of problems that affect them and their communities. It also provides a method for tackling more sensitive community issues (e.g., reduction of the risk of rape and/or violence and access to high-quality services and education) and their impact on other children, parents, and the community at

large. It can be used not only with affected and infected children, but with all other children. For this reason, ProVIC plans to extend the C2C approach to four new Champion Communities in Kisangani to address issues affecting OVC and children in general. This would bring the total number of Champion Communities using this innovative approach to 44.

### ***Coordination meeting with MINAS***

ProVIC ensures that its work is well integrated with the relevant government structures, including MINAS for work with vulnerable children. Under the leadership of MINAS, ProVIC hosted a coordination meeting with other partners, including the World Bank (Projet Enfants Dits de la Rue), USAID, and PNMLS to harmonize the coordination of OVC activities. In so doing, ProVIC became a member of the national OVC task force.

### ***Education and vocational training***

- Fourteen ProVIC grantees supported OVC with education and vocational training.
- Educational support consisted of paying school fees and distributing school kits.
- Vocational training differed from province to province. Workshops included sewing, information and computing technology (ICT), mechanics, beauty therapy, and small business development, among others.
- ProVIC had difficulty in Year 2 adopting the block grant strategy, but it is seriously considering the strategy as a way of sustaining the education and training of OVC in Year 3.
- A number of grantees have started to link up with schools, and are therefore able to enroll OVC over a number of years through one-time investments.



*Sewing workshop for OVC in Matadi.*



*ICT training center, AMO-Congo Lumumbashi.*

### ***Training workshop on child protection***

In July 2011, the six grantee coordinators from Kinshasa, three from Matadi, and the ProVIC care and support team took part in a training workshop on the development of a policy on the protection of children's rights.

International consultant Sian Long facilitated the workshop, and local consultant Emery Nynanka co-facilitated. The workshop aimed at developing and introducing child protection norms within local partners to ensure that NGOs recognize the responsibility they have for ensuring that their staff are not involved in child abuse and have the mechanisms to deal with complaints. A number of different tools were used to help elaborate the first child protection policy for each grantee.

This training will take place in Katanga and Sud Kivu in 2012, and the program will help grantees to adopt/adapt a child protection policy.

### ***Other activities***

- The care and support team took part in the PEPFAR data collection mission in Kisangani, with a view to providing information to government and international cooperation partners on gaps in HIV/AIDS services available in Kisangani. The mission was carried out in collaboration with PSI, the University of North Carolina, the School of Public Health, C-Change, International Medical Corps Goma, the United States Department of Defense, and USAID.
- An international HIV/AIDS trip was conducted to grantees in Kinshasa and Bas Congo (AMO-Congo in Kinshasa and Matadi, TIFIE Humanitarian, SWAA, JADISIDA, CEMAKI) to assess project implementation in the field. A second visit focused on supporting the care and support team in the development of their work plan for 2012.
- The care and support team worked with FANTA/LIFT to explore ways of collaborating with regard to food provision, nutritional support, and IGAs.
- Work sessions were conducted with PRONANUT to share ideas on the finalization of the national PLWHA care and support protocol.
- A draft exit plan for OVC of more than 18 years of age was developed and submitted to USAID.
- A work session was held with USAID to improve the OVC data sheet, with a particular focus on the Child Status Index.
- A work session was held with USAID on sustainability strategies for educational support: one-time investments, block grants, and IGAs within schools.

### ***Challenges and proposed solutions***

- It has been difficult to develop a strong system of referrals at the city level (e.g., hospitals and HCT and other technical services), as well as community-level referrals within Champion Communities (e.g., church groups, health care, civic groups, and women's groups).
- Creating sustainable mechanisms for self-help and C2C groups remains a challenge.

#### **Success stories**

##### **Bas Congo**

- ❖ JADISIDA organized a special C2C day in Matadi to celebrate Universal Children's Day. Three groups representing Champion Communities Kitomesa, Mvuzi, and Nsakala-Nsimba came together during a ceremony showcasing ProVIC's work with children. The mayor of Matadi, PNMLS, the PNLs, and other partners, including TIGO and Bralima, participated. Children spoke on health protection and HIV, and numerous requests were made to integrate all children and to use the C2C approach in schools throughout the province.

##### **Kinshasa**

- ❖ A child who had been marginalized and stigmatized by other children and the teachers in his school sought the help of a lawyer through partner PSSP and developed an advocacy project

at his school around Law No. 08/011 and the support of PLWHA and affected people. He was able to regain his dignity and he now has many friends. He continues to share information about the anti-discrimination law with others.

## **Intermediate Result 3: Strengthening of health systems supported**

### **Summary of activities and achievements in Year 2**

ProVIC's health systems strengthening and capacity development component aims to improve the quality of services in prevention, care, and support through capacity-building initiatives for national and provincial governments as well as ProVIC partners. Overall, ProVIC performed extremely well in achieving targets in most project areas—exceeding targets for 15 out of 20 PEPFAR indicators—despite some delays and the postponement of some activities. Project performance was comparatively lower only for health systems strengthening indicators, with 85 percent (342 out of 400) of all targeted health care workers trained in Year 2. Similar to Year 1 results, using sensitization activities to create demand for services among the general population and among MARPs showed high achievements: more than 150 percent of the targeted general population was reached through awareness-raising activities, for example.

ProVIC interventions around PMTCT, management of pediatric HIV/AIDS, and care and support also showed marked improvements over Year 1. For example, more than 120 percent of project-targeted pregnant women were tested for HIV and received their results in Year 2, compared with 60 percent in Year 1. Building on Year 1 achievements, ProVIC has continued to provide critical HIV/AIDS services to its beneficiaries in Year 2. Innovative activities that have been implemented include a new PMTCT protocol, the finger prick methodology for HCT, and USAID financial compliance training for ProVIC grantee partners.

In Year 3, ProVIC will continue to collaborate with international and national partners to coordinate and synergistically implement essential information and services to beneficiaries. ProVIC will also re-examine its targets to reflect the on-the ground realities and experiences of Year 2 activities. The launch of the project M&E database, anticipated during the second quarter of Year 3, will further strengthen data quality, and in turn, results reported.

### **Sub-IR 3.1: Capacity of provincial government systems supported**

#### ***Finalizing a capacity-building plan for the provincial government***

A capacity-building plan was designed in Year 1 for the provincial governments in the four ProVIC intervention provinces. The plan was based on an analysis aimed at identifying the main gaps in service delivery by the provincial Ministries of Health, Social Affairs, and Gender and Family.

Key gaps identified in the analysis of these provincial government bodies were weak coordination, poor planning, weak M&E systems, and insufficient human resources and financial management.

In order to disseminate and validate the provincial capacity development plan, three meetings were organized, in Bukavu, Lubumbashi, and Matadi, to share the plan with the provincial government and other partners. An additional meeting will take place in Kinshasa in Year 3.

At the meetings, provincial governments analyzed the findings outlined in the capacity-building plan, and after discussion and clarification on data collection, procedures, and analysis, they agreed that the problems identified were relevant. ProVIC proposed that more commitment was required from the local government and partners for effective implementation of the proposed activities, and support of other aspects unrelated to ProVIC's agenda. This observation was taken into account and an allocation of roles and responsibilities for activities outlined in the plan agreed upon by the different stakeholders.

### ***Supporting MINAS to develop training materials for care and support to OVC***

Many OVC training materials are not aligned with DRC national strategies, as they were introduced by different partners and were not created in collaboration with MINAS, thus reflecting only donor goals. In order to develop comprehensive, standardized training modules for social workers on the provision of care and support for OVC that reflect best practices and the national OVC plan, MINAS requested assistance from ProVIC.

Two local consultants collated all the available training materials related to working with OVC and coordinated two workshops. Workshop participants included a wide range of representatives and stakeholders (MINAS, PNMLS, PNLS, AMO-Congo, *Réseau des éducateurs des jeunes & enfants de la rue*, UNICEF, *Union Congolaise des Organisations des Personnes vivant avec le VIH*, FFP, *Comité d'appui au travail social de la rue*, *Centre Africain de formation des éducateurs sociaux*, Save the Children, and World Vision) in order to ensure quality, buy-in, and future collaboration on the rollout of the new training modules. In the first workshop, 20 participants reviewed the existing materials and the contents of the modules to be developed were agreed upon. In the second workshop, the draft modules were reviewed and feedback provided to the consultants by the representatives from the different organizations. The following outputs were developed by the consultants:

- Standardized module to train OVC service providers, as well as a trainee guide.
- Facilitator's guide and participant workbook still to be validated in Year 3.

In Year 3, ProVIC will support a training of social workers and the dissemination of the materials to the provinces.

### ***HIV/AIDS integrated training for service providers in selected Champion Communities***

ProVIC ran a series of HIV/AIDS integrated trainings for ProVIC-supported health facilities, using the Ministry of Health-recognized training modules in the HIV/AIDS package of services for different types of service providers, including medical doctors, nurses, pharmacists, social workers, and laboratory technicians across the four provinces. The integrated training focused on technical standards to ensure improvement in the quality of services and delivery of comprehensive services to PLWHA, OVC, MARPs, and the general population.

Depending on service coverage within the Champion Community, this training was adapted to address technical weaknesses of the grantees to effectively deliver PMTCT, HCT, and care and support services to the target groups.

A total of 342 participants of a proposed 400 (85.5 percent) have received this training in collaboration with the PNLS and MSH/SPS.

### ***Supporting joint supervision with government counterparts***

An essential element of ProVIC capacity-building is joint supervision of activities with the PNLS. PNMLS and MINAS provincial staff support service providers to deliver high-quality, comprehensive services to clients. These supportive supervision sessions provide an opportunity for senior ProVIC staff to assess and coach service providers in order to improve their performance as well as the quality of services.

In total, 48 facilities received joint supervision in Year 2, which also contributed to reinforcement of the link between community-based services and health facilities (improving the referral and counter-referral systems).

### ***Supporting PNMLS coordination meetings at the provincial level***

As identified in the provincial capacity-building plan, coordination remains a weak area in ProVIC-supported provinces. Internal coordination within and between government structures, as well as external coordination with implementing partners, requires improvement to allow PNMLS to play its role fully. ProVIC planned 16 quarterly coordination meetings in the four provinces for Year 2, out of which ten were implemented. The focus of these meetings was to discuss with the relevant stakeholders the progress, gaps, and proposed solutions in HIV/AIDS interventions in each province.

### ***Reinforcing the capacity of service providers and implementing partners in biomedical waste management***

While implementing ProVIC activities, it is mandatory for ProVIC to comply with national and USAID environmental rules. ProVIC has the responsibility to share these rules to the implementing partners. Early assessments identified that biomedical waste was not well managed in the past by the health facilities in ProVIC's areas of implementation. During Year 2, the project conducted several onsite trainings for service providers to develop a good management system for biomedical waste. A total of 264 service providers were trained to manage waste produced in the facilities (Bukavu, 144; Kinshasa, 40; Lubumbashi, 20; and Matadi, 60). Adapted equipment was also provided to the facilities.

### ***Providing technical assistance in policy development and implementation***

ProVIC was involved with the PNLS to adopt the new WHO PMTCT protocol to deliver comprehensive PMTCT services. This was described in detail in the PMTCT section.

### ***M&E training for ProVIC partners***

In Year 2, ProVIC provided training to 103 participants among ProVIC's 14 grantees and PNMLS, MINAS, and the PNLS to ensure a common understanding of PEPFAR's indicators and their application through the ProVIC M&E system. The training focused on ProVIC data collection and reporting, as well as complicated issues in moving toward alignment of PEPFAR's new-generation indicators to the national M&E framework.

### **Sub-IR 3.2: Capacity of NGO partners improved**

#### ***Strengthening the technical and managerial capacity of NGO partners***

ProVIC has a key objective of improving grantee's capacity to implement activities according to USAID rules and regulations as well as the objective of improving the organizational capacity of these NGOs, particularly in financial management, administrative systems, and M&E.

ProVIC conducted a managerial and technical capacity assessment of each of the grantees. Based on this analysis, trainings were organized on compliance with USAID rules and regulations. ProVIC invited a regional consultant financial specialist to the DRC who conducted three workshops (two in Kinshasa and one in Lubumbashi) for both grantees and ProVIC finance and grant management staff. Topics covered in the training included cost principles; procurement; financial operations and transactions; allowable, allocable, and reasonable expenses; audit readiness and internal controls; subcontracting; human and material resources management; marking and branding; reporting; conflict of interest; recordkeeping; and cost-share/matching. Partners welcomed the training as highly useful.

The consultant has been working with ProVIC grant officers, accountants, and partner organization finance staff to develop a capacity-building strategy to improve financial and program management systems over the next two to three years. A second organizational development specialist consulted with ProVIC technical staff, regional coordinators, and grantee managers to develop a joint strategy on organizational development that will complement the financial strengthening strategy and ensure that ProVIC has the capacity to support its partners to be effective in delivering the program and to become potential USAID partners.

#### ***Challenges and proposed solutions***

- It has been difficult to reach an agreement regarding a per diem rate for government counterparts. Negotiations on this have allowed ProVIC to collaborate with national counterparts to conduct trainings, supportive supervision, and other activities.
- Weak analysis of supervision data needs to be addressed. It has been proposed that ProVIC support meetings that review supervision data in order to improve the quality of services.
- Throughout the year, there were a number of delays in getting information from the grantees, which was linked to the lack of standardized data collection tools, the need for greater guidance on the meaning of the indicators, and the lack of a database in which to collate the information. Action was taken to revise adapted data collection tools, and the M&E team has organized a training session to improve understanding of national and PEPFAR indicators among grantees and government employees responsible for data collection. Finally, ProVIC developed a database.

### **Sub-IR 3.3: Strategic information systems at the community and facility levels strengthened**

Over the course of Year 2, the ProVIC M&E system was consistently revised and refined to produce high-quality data on a monthly basis through multiple partner and activity types, including NGO partners, community-level partners, and public- and private-sector hospitals and clinics. This was done through a system of training and one-on-one coaching with partner “M&E officers”, many of whom had very low capacity using M&E tools and very little experience in collecting and reporting data.

By the second half of Year 2, ProVIC had begun conducting routine data quality analysis to examine data quality and issues with data collection and reporting and develop a feedback system of recommendations for ProVIC partners. Over time, data quality improved, although some care and support indicators were problematic as partners struggled to report on the number of individuals served rather than the number of services offered.

These problems will be tackled as ProVIC finalizes its online database. During Q4, ProVIC developed the complex architecture of this system and plans to populate the database in Q1 of Year 3.

#### ***Strengthening the ProVIC M&E system***

ProVIC quarterly coordination meeting: In July 2011, ProVIC convened all Kinshasa-based technical staff, the entire M&E team (including the Washington, DC-based M&E specialist), and provincial coordinators from all four ProVIC regions for its first M&E quarterly coordination meeting in Kinshasa. The M&E team presented Q3 Year 2 achievements and discussed ongoing challenges and potential solutions to obtaining timely reports from implementing partners. With leadership from the Washington, DC-based M&E specialist, the Performance Monitoring and Evaluation Plan was also revised to remove indicators that do not reflect ProVIC’s ongoing activities, and to update targets for Years 3 through 5.

PEPFAR indicators workshop: In August 2011, ProVIC’s national M&E and care and support specialists participated in a PEPFAR workshop aimed at improving understanding and interpretation of PEPFAR indicators among PEPFAR implementing partners. The workshop also provided a forum for ProVIC to engage PEPFAR workshop facilitators in discussions around project-specific challenges, both at the workshop site and at ProVIC’s office. Information and resources from this workshop were shared with the entire team—both to inform ProVIC’s database development work and to determine how to best follow up, particularly with ProVIC’s partners, to address inconsistent approaches to data collection for certain indicators (particularly for care and support, which have, in turn, led to the need to revisit and adjust M&E data reported by certain partners).

#### ***Making data collection tools available to implementing partners and enhancing implementing partner M&E capacity***

Two key activities supported ProVIC partners’ capacity to conduct essential M&E work in Year 2. First, ProVIC led an orientation on project indicators, targets, and performance tracking with project partners in April 2011. A more detailed, week-long workshop in each region then

followed in June, covering data collection and reporting tools and PEPFAR reporting requirements. These workshops, which included a total of 101 participants, were each facilitated by two M&E specialists, in collaboration with PNMLS, the PNLS, and MINAS.

### ***Strengthening the quality assurance system***

In an effort to maintain high-quality data and standards around ProVIC's reporting and information systems, the Washington, DC-based M&E specialist traveled to Kinshasa in January 2011 to lead a four-day workshop on data quality for the M&E team. Discussions centered on field M&E experiences during the first year of implementation, and the M&E team shared best practices and challenges, including ways to address them. Workshop activities also highlighted the importance of the team's common understanding of PEPFAR indicators.

In July 2011, the Washington, DC-based, national, and Katanga M&E specialists collaborated closely to finalize ProVIC's data quality assurance tools. After field-testing the tools with four implementing partners in Kinshasa, the national and Katanga M&E specialists conducted data quality assurance exercises in Bas Congo, Katanga, and Sud Kivu with the other regional M&E specialists in September. The regional M&E specialists will continue to supervise implementing partners and monitor their implementation of Year 2 recommendations that emerged from the findings in order to continue to improve data quality. ProVIC will continue to perform internal audits of implementing partner activities every six months.

### ***Supporting M&E reporting systems***

To improve ProVIC's M&E system, the project has begun developing a web-based project M&E database in close collaboration with the consulting firm Vera Solutions. A Vera Solutions consultant traveled to the DRC in September, spending a full week orienting the M&E team to the database and working closely with the team to refine the database's architecture. The database will serve to increase access to data on project achievements in real-time and across provinces and continents; increase ProVIC's capacity to manipulate and analyze data for each project component, and thereby generate more sophisticated reports (especially for care and support activities and indicators, which require more in-depth monitoring); increase reporting efficiencies by reducing the number of hours required for manual data entry; allow tracking of individual beneficiaries; allow more coordinated and regular analysis of data as a means to monitor and increase support for lower-performing project activities as needed; and reduce human reporting errors, thereby improving data quality. The database will be used by the national and regional M&E specialists as both a regular project management and M&E tool and to generate reports, and by PATH headquarters for real-time monitoring of project achievements. This platform is scheduled for launch in December 2011.

### ***Supporting M&E in Champion Communities***

In January 2011, ProVIC staff, including the M&E team, participated in a rigorous training session on the Champion Community approach. As the M&E specialists will play a pivotal role in supporting local organizations and communities in monitoring their activities, their strong understanding of the Champion Community model is essential to ensuring that implementation progresses as anticipated. Around this time, the M&E team and other technical staff also participated in a four-day, hands-on TOT workshop on participatory learning and action,

facilitated by the Washington, DC-based M&E specialist. ProVIC staff then trained selected representatives from local partner organizations to use participatory learning and action techniques to conduct qualitative, participatory baseline assessments among Champion Communities in all four provinces, with ProVIC staff supervision. The February and March assessments, in the form of focus group discussions, focused on mapping communities' utilization of and access to existing HIV/AIDS services and resources, assessing knowledge and behavior around HIV/AIDS, and sensitizing community members to the Champion Community approach. Visual tools, such as problem tree analysis, social/resource mapping, and Venn diagrams were used to encourage discussions with PLHWA, married women and men, and OVC.

### ***Providing support for M&E activities at the national and provincial levels to the PNLS, PNMLS, and MINAS***

Reviewing the DRC 2010 National AIDS Spending Assessment (NASA): During Year 2, ProVIC's regional and national M&E specialists attended a series of PNMLS task force meetings to review 2010 national HIV/AIDS spending at the respective levels. ProVIC also provided financial support to PNMLS to retain a consultant to conduct the NASA and present results to stakeholders, including ProVIC; the NASA tool tracks this spending along categories such as prevention, care, and support, OVC, program management and administration, social protection and social services, and research.

Supporting M&E activities at the provincial level: At the provincial level, the three regional M&E specialists participated in the PNLS annual review and finalization of the Provincial Health and Development Plan for 2011 through 2015. All contributed to their respective provinces in working directly with PNMLS. The Bas Congo M&E specialist participated in the data quality audit on children born to HIV-positive mothers under early infant diagnosis. In Katanga, the regional M&E specialist facilitated a workshop to design risk and vulnerability mapping of CSWs and MSM; the mapping has been used to better track and provide mobile HCT services to these MARPs. The Sud Kivu M&E specialist participated in a seven-day planning workshop to develop a provincial M&E strategy.

### ***Challenges and proposed solutions***

Using PEPFAR indicators continues to be a challenge for both ProVIC staff and partners, with implications for data quality and reporting. ProVIC continues to work closely with all partners to provide guidance on interpreting and operationalizing the indicators. To support these efforts, PATH's headquarters team is also developing a PEPFAR project indicator "mini-manual" in both French and English for use by ProVIC and its partners. Stronger, consistent understanding of these indicators and their use within the context of ProVIC's activities will help yield data that are collected and reported more consistently. Launching the M&E database will also support improved data quality, allowing more efficient and accurate monitoring of individual beneficiaries and facilitating monthly tracking of care and support indicators in particular.

ProVIC's referral and counter-referral systems require significant attention. Service providers, for example, have not been routinely using data collection tools to monitor referral and counter-referral systems between the communities and health facilities. To help address these system

challenges, ProVIC plans to map service availability in ProVIC-supported health zones as a means to better link referral and counter-referral systems with these services.

Despite ProVIC's ongoing efforts to provide guidance and technical support to implementing partners, some partners continue to grapple with reporting requirements and deadlines. ProVIC will provide increased, focused oversight to these partners in the year ahead.

## **SECTION 2: ADMINISTRATION AND FINANCE**

During Year 2, the ProVIC team underwent considerable changes in administrative and financial systems and personnel in an effort to respond to management deficiencies, streamline operations, and respond to auditor and USAID recommendations.

### **Changes in management and recruitment**

In Year 2, PATH changed the management structure by making the Chief of Party a PATH staff member rather than a Chemonics staff member. In April 2011, Trad Hatton became the new ProVIC Chief of Party, coming to the position with 13 years of development experience, including experience as the deputy director of a previous HIV/AIDS program in the DRC. This experience with both USAID and within the DRC has yielded tangible results in the six months since this change in management.

Additionally, PATH replaced the Finance and Administrative Specialist position with Jean Ntumba, who has many years of experience managing the finances of USAID projects, including most recently with Chemonics.

ProVIC also added the position of Senior Grants Manager to provide greater supervision and systems management of ProVIC's complex granting system. The Senior Grants Manager comes to ProVIC with both USAID grants management experience and audit experience with one of the Big Four international auditors.

Finally, ProVIC added the essential position of Logistics Officer to improve quantification, planning, and management of the supply chain of HIV test kits, ARVs, and other supplies.

### **Granting**

#### ***Standard grants***

In Year 2, ProVIC issued 14 standard grants to local organizations that cover the catchment areas of the project. Partners include local NGOs, faith-based groups, youth groups, associations of people living with HIV/AIDS (PLWHA), cooperatives, and educational groups. ProVIC Champion Communities are supported by these grantees. Table 9 on the next page lists the 14 grantees and the activities they implement.

**Table 9. ProVIC grantees and activities.**

Region	Grantee
Bas Congo	Jeunesse Active pour le Développement Intégré et lutte contre le VIH/SIDA
	Centre Maman Kinzembo*
Katanga	Bread and Knowledge Too*
	Bureau Diocésain des Oeuvres Médicales
	Organisation non Gouvernementale Laïque a la Vocation Socio-Economique du Congo
	World Production / School Prevention AIDS and Education Children
Kinshasa	Action Communautaire SIDA / Avenir Meilleur pour les Orphelins au Congo
	Progrès Santé Sans Prix*
	Fondation Femme Plus*
	Réseau National des Organisations d'Assise Communautaire des Groupes de Support des Personnes Vivant avec le VIH/SIDA
	Society for Women and AIDS in Africa
	Teaching Individuals and Families Independence through Enterprise
Sud Kivu	Association Coopérative en Synergie Féminine*
	Association de lutte pour la promotion et la protection des droits de la femme et de l'enfant*

All grantees work in either HCT, care and support or both areas. Those marked with an asterisk (\*) also work in PMTCT. All grantees support Champion Communities.

### ***Fixed obligation grants***

ProVIC began developing nine fixed obligation grants to private-sector health facilities. In Year 3, eight of the grants will support PMTCT and HCT, and some will also provide other related care and support services to communities in their health zones. The ninth grantee will provide HCT services and conduct behavior change communication (BCC) activities in communities around Kinshasa.

### ***Agreements with public facilities (collaborative accords)***

ProVIC began the development of 13 collaborative accords to public health facilities. These agreements, with a total award value of \$319,900, will support ProVIC's HCT, PMTCT, outreach, and other HIV/AIDS care and support-related interventions in Kinshasa, Bas Congo, Katanga, and Sud Kivu provinces. These facilities represent a continuation of ProVIC support, formerly through the memorandum of understanding/direct support mechanism.

### ***Grants workshop***

In August 2011, ProVIC's entire grants management team gathered in Kinshasa for an intensive, five-day grants workshop. The workshop brought together ProVIC and/or PATH staff representing various perspective of grants implementation—including the regional grants managers and accountants from all four project-supported regions, ProVIC's National M&E Specialist, the Kinshasa-based technical specialists, ProVIC's Chief and Deputy Chiefs of Party, and the Senior Finance and Administration Specialist. These highly participatory discussions were led by DC-based PATH Program Associate, who brought lessons learned from supporting

the original standard grants and knowledge of PATH's systems, ProVIC's Chief of Party, and other team members. Workshop objectives included building understanding of ProVIC's granting mechanisms from both a technical and financial perspective; refining the internal systems needed to support these mechanisms; determining ways to improve grantee reporting; planning for quarterly grantee technical review meetings, and for USAID compliance trainings with standard grantees at the beginning of Year 3; and preparing ProVIC's Year 3 FOGs, collaborative accords, and standard grant amendments.



*The ProVIC grants team during their August workshop in Kinshasa.*

The team also introduced grants management and reporting tools to help ensure grantee compliance, improve the quality of financial and technical reporting, and contribute to better coordination and communication among ProVIC's M&E, technical, grants management, and administrative and financial teams. These efforts will allow ProVIC to react more quickly to grantees' needs on the ground as needed for improved grantee performance.

### **Procurement and commodities management**

ProVIC procurement systems underwent significant improvements in Year 2, and ProVIC was able to sustain a steady supply of HIV tests and commodities, with the exception of two one-month stockouts of test kits. In spite of this gap, however, ProVIC met its HCT targets. The project is currently working closely with the Supply Chain Management System (SCMS) project, which will take over responsibility for procurement of commodities from ProVIC. ProVIC will forecast needs, SCMS will procure the commodities, and ProVIC will distribute them.

Recognizing significant systemic issues with procurement, stocking, and distribution of test kits and supplies in Year 1, ProVIC undertook the following steps to improve commodities management:

1. An international consultant assessed ProVIC's systems and structure in relation to commodity management and provided recommendations, which have been followed.
2. A logistics officer was hired in Q3 who can focus exclusively on the quantification, management, and distribution of HIV test kits, ARVs, and other supplies. The logistics officer is also training ProVIC partners to improve management on the partner side.
3. ProVIC has identified a sole-source vendor for HIV tests, which will greatly reduce delays and errors in comparing bids.

### **Audit and financial review**

During Year 2, ProVIC received a Regional Inspector General (RIG) audit and a financial review by the USAID Mission.

The RIG audit began in April 2011, and continued through the end of the project year. The auditors had nine major findings, all of which have been addressed by PATH. They included issues around procurement of and budgeting for commodities; granting; and management. During the course of the year, PATH increased its on-the-ground procurement capacity both by hiring a procurement officer in Kinshasa and by providing more oversight from headquarters. We believe that we are now in complete compliance with USAID regulations, and we are attending to the needs of our beneficiaries. In the coming year, ProVIC will rely on the assistance of SCMS to procure commodities. Grant scopes of work and budgets have been clarified, and back payments to grantees were made once PATH received the proper documentation. And PATH resolved many of the on-the-ground managerial problems by replacing the Chief of Party with an excellent manager who is technically sound and has considerable experience working in the DRC.

USAID also conducted a financial review, starting in July 2011. We have not yet seen the results of this review, but we are confident that there will be no major findings.

## ANNEX A. YEAR 2 PROVIC RESULTS AGAINST PEPFAR INDICATORS AND TARGETS

PEPFAR Indicator	Year 1 Achievement (in numbers)	Year 2 Annual Target (per 2011 PMP)	Year 2 Achievements (in numbers)					% Achievement Against PMP	Comments	
			Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year 2 Cumulative Achievement			
IR-1: HCT and prevention services expanded and improved in target areas										
Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened										
P8.1D <b>Number</b> of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	316,302	360,000	93,985	33,244	117,884	298,827	543,940	151.1%	Data on awareness-raising among the general population were collected based on activities with small groups of less than 25 people or with individuals. Numbers of the targeted population reached with individual and/or small group-level preventive interventions that are primarily focused on abstinence and/or being faithful (per P8.2D below) were not reported among the general target population; this oversight has been corrected in Q4 of Y2.	
Male	N/A	N/A	42,151	14,852	54,077	141,160	252,240	N/A		
Female	N/A	N/A	51,834	18,392	63,807	157,667	291,700	N/A		
10-14 years old	N/A	N/A	2,696	1,432	3,830	15,194	23,152	N/A		
15+ years old	N/A	N/A	91,289	31,812	114,054	283,633	520,788	N/A		
P8.2D <b>Number</b> of the targeted population reached with individual and/or small group-level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	8,922	36,000	11,208	5,557	50,782	81,007	148,554	N/A	Individuals sensitized in small groups or individually consisted of young people in schools and couples in churches.	
Male	N/A	N/A	5,611	2,825	22,916	40,221	71,573	N/A		
Female	N/A	N/A	5,597	2,732	27,866	40,786	76,981	N/A		
10-14 years old	N/A	N/A	1,597	890	10,469	8,794	21,750	N/A		
15+ years old	N/A	N/A	9,611	4,667	40,313	72,213	126,804	N/A		
P8.3D <b>Number</b> of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	31,170	12,000	34,710	512	15,269	24,130	74,621	621.8%	Performance against this indicator can be attributed to the success of mobile VCT primarily targeting MARPs. These mobile VCT activities are accompanied by other awareness-raising activities among this target population.	
By MARP type: CSW, IDU, MSM										
CSW	4,092	N/A	5,585	203	4,894	6,338	17,020	N/A		
Truckers	16,659	N/A	9,992	205	5,709	8,475	24,381	N/A		
Fishermen	3,610	N/A	1,823	2	1,432	1,901	5,158	N/A		
Miners	5,953	N/A	8,664	102	1,291	4,908	14,965	N/A		
MSM	392	N/A	1,026	0	226	71	1,323	N/A		
Other vulnerable populations	N/A	N/A	7,620	0	17,17	2,437	11,774	N/A		
Male	N/A	N/A	26,247	343	9,480	13,047	49,117	N/A		
Female	N/A	N/A	8,463	169	5,789	11,083	25,504	N/A		
Sub-IR 1.2: Community- and facility-based HCT services enhanced										
P11.1D <b>Number</b> of individuals who received testing and counseling (T&C) services for HIV and received their test results	77,936	173,088	63,762	10,902	40,421	47,625	162,710	94.0%	These data account for HIV testing at the integrated, mobile, and community VCT site levels, and for screening for PMTCT and EID, to better monitor the performance of each respective project component. The dramatic increase in HIV testing results in the 4th quarter is attributable to the use of mobile VCT tents, an improved form of mobile VCT.	
By sex: Male and	43,026	N/A	36,003	6,247	21,614	25,126	88,990	N/A		
Female	34,890	N/A	27,759	4,655	18,807	22,499	73,720	N/A		
By age: <15 and	6,482	N/A	889	137	606	900	2,532	N/A		
15+	71,454	N/A	62,873	10,765	39,815	46,725	160,178	N/A		
By test result: Positive	2,964	N/A	1,804	417	976	1,537	4,734	N/A		
By test result: Negative	74,972	N/A	61,958	10,485	39,445	46,088	157,976	N/A		
Individual counseling/test	N/A	N/A	63,570	10,850	36,804	43,301	154,525	N/A		
Couple counseling/test	N/A	N/A	192	52	3,617	4,324	8,185	N/A		

PEPFAR Indicator		Year 1 Achievement (in numbers)	Year 2 Annual Target (per 2011 PMP)	Year 2 Achievements (in numbers)					% Achievement Against PMP	Comments
				Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year 2 Cumulative Achievement		
	CSW (for concentrated epidemics)	N/A	N/A	3,810	217	1,386	1,347	6,760	N/A	
	IDU (for concentrated epidemics)	N/A	N/A	0	0	0	108	108	N/A	
	MSM (for concentrated epidemics)	N/A	N/A	846	73	144	18	1,081	N/A	
	TB	N/A	N/A	215	129	347	480	1,171	N/A	
<b>Sub-IR 1.3: PMTCT services improved</b>										
P1.1D	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	6,861	23,000	7,772	7,161	6,463	6,940	28,336	123.2%	PMTCT sites were strategically selected to help ensure achievement of annual targets. Data are collected on a monthly basis at 16 PMTCT sites in the 4 provinces (4 in Kinshasa, 5 in Bas-Congo, 5 in Katanga, and 2 in Sud Kivu 2).
	Known positives at entry	19	N/A	27	29	28	26	110		
	Number of new positives identified	136	N/A	130	133	109	111	483		
P1.2D	Percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child transmission	1	75%	N/A	N/A	N/A	N/A	77%	N/A	
	Numerator: Number of known HIV-positive pregnant women who received ARVs to reduce risk of MTCT (reported)	99	326	105	118	117	105	445	136.5%	
	By prophylactic regimens: Single-dose Nevirapine only	91	N/A	92	115	81	16	304	N/A	
	By prophylactic regimens: Prophylactic regimens using a combination of 2 ARVs	0	N/A	0		0	0	0	N/A	
	By prophylactic regimens: Prophylactic regimens of 3 ARVs	4	N/A	0	0	19	88	107	N/A	Application of the new WHO standards on PMTCT, for which planning began during the 2nd half of Y2, began in June 2011 in ProVIC-supported maternity wards (with a gradual expansion to the different provinces). Q3 data reflect the launch of this new strategy with the 19 pregnant women who have benefited from ARV prophylaxis. Triple therapy implies prophylaxis with 3 molecules: AZT from the 14th week of pregnancy, AZT +3 TC + NVP at delivery, and 3TC + NVP for 7 days following delivery.
	By prophylactic regimens: ART	5	N/A	13	3	17	1	34	N/A	
	Denominator: Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)	155	N/A	157	160	134	126	577	N/A	
C4.1D	Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	11.6%	20%	40%	4%	34%	58%	31.5%	157.7%	ProVICs intensified tracking system includes identifying HIV-positive pregnant women, their children, and fathers in the 4 intervention areas. Phone calls are made and followed by home visits if mothers do not then show up with their children for early diagnosis and testing.
	Numerator: Number of infants who received an HIV test within 12 months of birth during the reporting period	18	N/A	63	6	45	73	187	N/A	
	Infants who received virological testing in the first 2 months	2	N/A	18	3	14	40	75	N/A	
	Infants who were tested virologically for the first time between 2 and 12 months or who had antibody test between 9 and 12 months	16	N/A	45	3	31	34	113	N/A	
	Denominator: Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positives at entry)	155	N/A	157	162	137	137	593	N/A	
C4.2D	Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	1.3%	20%	0%	3.8%	16.4%	29.4%	12.0%	59.9%	
	Numerator: Number of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	2	N/A	5	7	22	37	71	N/A	
	Denominator: Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positives at entry)	155	N/A	157	162	137	137	593	N/A	

PEPFAR Indicator		Year 1 Achievement (in numbers)	Year 2 Annual Target (per 2011 PMP)	Year 2 Achievements (in numbers)					% Achievement Against PMP	Comments
				Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year 2 Cumulative Achievement		
IR-2: Care, support and treatment for PLWHA and OVC improved in target areas										
Sub-IR 2.1: Palliative care strengthened										
C1.1D <b>Number</b> of eligible adults and children provided with a minimum of one care service		19,524	18,930	2,716	577		17,017	20310	107.3%	Performance against this indicator during the last 2 quarters due to multifaceted support to OVC and PLWHA beneficiaries to which grantees have responded during home visits, meetings of PLWHA self-support groups, C2C groups, and medical visits. Close monitoring of grantees and technical assistance from ProVIC during implementation has also contributed to high numbers achieved. Organization of ProVIC implementing partners' activities around champion communities has led to multiple counting of beneficiaries who returned for the same service during the reporting period. ProVIC's M&E database, which will launch during Q2 of Y3, will be especially helpful in tracking beneficiaries and reduce instances of multiple counting
	By Age: <18,	12,618	N/A	1,775	413		9,507	11,695	N/A	
	By Age: 18 +	6,906	N/A	941	164		7,510	8,615	N/A	
	By sex: Male	8,339	N/A	987	215		6,466	7,668	N/A	
	By sex: Female	11,185	N/A	1,729	362		10,551	12,642	N/A	
C2.1D <b>Number</b> of HIV-positive adults and children receiving a minimum of one clinical service		3,089	7,924	788	168		6726	8,638	109.0%	See above comments for indicator C1.1.D; Note also that some grantees have had to support more beneficiaries than anticipated during Y2 due to high demand.
	By age: <15	658	N/A	99	15		233	347	N/A	
	By age: 15 +	2,431	N/A	689	153		6,493	7,335	N/A	
	By sex: Male	1,113	N/A	246	53		1,750	2,049	N/A	
	Female	1,956	N/A	542	115		4,976	5,633	N/A	
C2.2D <b>Number</b> of HIV-positive persons receiving cotrimoxazole prophylaxis		1,552	7,825	N/A	N/A		6372	8,206	104.9%	High performance reflects the effective role of CTX, administered monthly by ProVIC, in preventing recurrent opportunistic infections among PLWHA. Data reporting concerns related to multiple counting are being resolved via adaptation of the data collection tools already available to ProVIC implementing partners, as well as by monitoring individual beneficiaries (which the M&E database will support).
	By sex: Male	N/A	N/A	280	53		1,719	2,052	N/A	
	Female	N/A	N/A	428	115		4,653	5,196	N/A	
	By age: <15	266	N/A	67	4		184	255	N/A	
	By age: 15+	1,286	N/A	641	153		6,188	6,982	N/A	
C2.3D <b>Number</b> of HIV-positive clinically malnourished clients who received therapeutic or supplementary food		785	594	183	0		1074	1257	211.6%	High achievement is in part due to the fact that therapeutic support and supplementary feeding to malnourished PLWHA is a lengthy process that begins with body mass index and anthropometric measurements in children, complemented by further analysis. ProVIC grantees work with nutritionists, who upon diagnosis advise the provision of a nutritional kit. During Y3, ProVIC will continue this support while the PRONAUT guide on national nutritional support standards is finalized; this guidance will help standardize how malnourished PLWHAs to be supported are identified. Engagement of additional nutritionists will also help reduce delays in service provision. Reporting against this indicator will be further improved
	By sex: Male	N/A	N/A	55	0		239	294	N/A	
	Female	N/A	N/A	128	0		835	963	N/A	
	By age: <15	N/A	N/A	16	0		67	83	N/A	
	By age: 15+	N/A	N/A	0	0		1,007	1,007	N/A	

PEPFAR Indicator		Year 1 Achievement (in numbers)	Year 2 Annual Target (per 2011 PMP)	Year 2 Achievements (in numbers)					% Achievement Against PMP	Comments
				Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year 2 Cumulative Achievement		
	Pregnant	N/A	N/A	33	0		4	37	N/A	during Y3 by identifying malnourished PLWHA in self-support groups in the context of Champion Communities. Emphasis will be placed on preventive aspects of malnutrition as recommended by FANTA.
	Postpartum	N/A	N/A	134	0		0	134	N/A	
P7.1D Number of people living with HIV/AIDS (PLWHA) reached with a minimum package of prevention with PLWHA interventions		1,845	5,944	116	0	4,208	5,857	10,181	171.3%	These results are attributed to the establishment of PLWHA self-support groups since Q3. This has been a gradual and ongoing process.
	Number reached in clinic/facility setting	N/A	N/A	0	0	124	0	124	N/A	
	Number reached in community/home-based setting	N/A	N/A	116	0	4,084	761	4,961	N/A	
Sub-IR 2.2: Care and support for OVC strengthened										
C5.1D Number of eligible clients who received food and/or other nutrition services		1,305	5,678	525	110		7,901	8,536	150.3%	High achievement is attributable to the distribution of food kits to OVC and PLWHA per PEPFAR guidance and national standards. Performance against this Indicator has improved with the introduction of community meals and cooking demonstrations in PLWHA self-support groups. Preventive nutrition as an additional area of emphasis will be incorporated into ProVIC's nutritional support approach, per expert guidance from FANTA and LIFT.
	By sex: Male	N/A	N/A	211	36		3,192	3,439	N/A	
	Female	N/A	N/A	314	74		4,709	5,097	N/A	
	By Age: <18	690	N/A	472	105		4,913	5,490	N/A	
	18+	615	N/A	53	0		2,988	3,041	N/A	
	Pregnant	0	N/A	0	5		41	46	N/A	
	Lactating women	0	N/A	0	1		16	17	N/A	
C5.3.D Number of eligible children provided with health care referral		651	3,000	1	304		6,093	6,398	213.3%	High achievement is due to improved OVC support in C2C groups, and during home visits which have helped to identify more referral cases. C2C groups have also since been introduced in consultation with local fairground medical staff, whom ProVIC has also targeted to help increase OVC access to services.
C5.4.D Number of eligible children provided with educational and/or vocational training		3,296	1,000	1,011	0		1,061	2,072	207.2%	ProVIC grantees have supported OVC education in the form of payment of school fees and vocational training. Gains achieved through Y1 funding contributed to high achievement during Q1 of Y2, and in turn, to numbers achieved during Y2.
C5.5.D Number of eligible adults and children provided with protection and legal aid services		6	35	0	0		12	12	34.3%	Performance against the indicator depends on the assimilation of PLWHA's, OVC's, and their families' rights with an awareness of the law governing the protection of PLWHA. Fear of retaliation and lack of access to legal support have made some PLWHA reluctant to disclose violations of their rights. During Y2, ProVIC began collaborating with the Centre National Solidarity, an organization specializing in legal care for victims of rights violations. ProVIC held 3 meetings with the Center and its Kinshasa grantees. If this pilot activity proves successful, it will be expanded to other ProVIC provinces.
	By Age: <18	0	N/A	0	0		8	8	N/A	
	By Age: 18+	6	N/A	0	0		4	4	N/A	
C5.6.D Number of eligible adults and children provided with psychological, social or spiritual support		9,312	9,250	N/A	N/A		14,726	17,866	193.1%	Self-support groups, C2C groups, and home visits constitute ideal settings for the delivery of this service. Performance is expected to further improve with ongoing solidarity initiatives in Champion Communities and efforts to engage parishes in spiritual support to OVC, PLWHA, and their families.
	By Age: <18	6,934	N/A	197	0		7,768	7,965	N/A	
	By Age: 18+	2,378	N/A	340	0		6,957	7,297	N/A	
C5.7.D Number of eligible adults and children provided with economic strengthening services		521	201	175	0		686	861	428.4%	During Y2, ProVIC beneficiaries received financial support to initiate individual IGAs. The recruitment of local consultants in Y3 will support grantees in developing targeted IGAs and better linking them with market opportunities.
	By Age: <18	248	N/A	75	0		117	192	N/A	
	By Age: 18+	273	N/A	100	0		569	669	N/A	

PEPFAR Indicator	Year 1 Achievement (in numbers)	Year 2 Annual Target (per 2011 PMP)	Year 2 Achievements (in numbers)					% Achievement Against PMP	Comments	
			Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year 2 Cumulative Achievement			
IR-3: Strengthening of health systems supported										
Sub-IR 3.1: Capacity of provincial government health systems supported										
Sub-IR 3.2: Capacity of nongovernmental health providers improved										
H2.3D Number of health care workers who successfully completed an in-service training program		458	400	0	194	148	0	342	85.5%	During Q3, a total of 148 health workers participated in a training on provision of an integrated package of HIV/AIDS services.
	PMTCT	N/A	N/A	0	74	63	0	137	N/A	Doctors and nurses participated in a training on PMTCT.
	Outreach with general population (sexual prevention)	N/A	N/A	0	28	33	0	61	N/A	Community health workers attended a training session on prevention.
	Male circumcision	N/A	N/A	0	0	0	0	0	N/A	
	Injection safety	N/A	N/A	0	0	0	0	0	N/A	
	Blood safety	N/A	N/A	0	0	0	0	0	N/A	
	Intravenous and non-intravenous drug use	N/A	N/A	0	0	0	0	0	N/A	
	Testing and counseling	N/A	N/A	0	102	62	0	164	N/A	Doctors, nurses, and laboratory technicians participated in trainings on counseling and testing.
	Adult care and support	N/A	N/A	0	33	52	0	85	N/A	Community health workers attended training sessions on care and support.
	Adult treatment	N/A	N/A	0	113	63	0	176	N/A	Doctors and nurses participated in a training on adult HIV/AIDS treatment.
	Pediatric care and support	N/A	N/A	0	0	14	0	14	N/A	
	Pediatric treatment	N/A	N/A	0	113	36	0	149	N/A	Doctors and nurses participated in a training on pediatric HIV/AIDS treatment.
	TB/HIV	N/A	N/A	0	74	63	0	137	N/A	Doctors and nurses participated in a training on HIV-TB co-infection.
	Laboratory infrastructure	N/A	N/A	0	28	25	0	53	N/A	Laboratory technicians participated in a training on laboratory infrastructure.
	Strategic information	N/A	N/A	0	74	63	0	137	N/A	Doctors and nurses participated in a strategic information training session.
	Other (please specify)	N/A	N/A	0	20	27	0	47	N/A	Pharmacy attendants participated in a training session on the management of medication.

## ANNEX B. YEAR 2 FINANCIAL REPORT

Contract No.  
Report Date:  
Period Covered by this Statement:

GHH-I-00-07-00061-00, Order No. 03  
November 25, 2011  
July 1, 2011-September 30, 2011

Budget Line Items	Total Award Budget	Current Obligation	Expenditures Current Period 7/1/11 - 9/30/11	Expenditures Project To Date 9/30/09 - 9/30/11***	Current Obligations Remaining	Total Budget Remaining
Salary and Wages	2,724,498	1,157,388	154,217	880,572	276,816	1,843,926
Fringe Benefits	817,349	347,217	45,163	261,869	85,348	555,480
Consultants *	0	30,000	24,317	24,317	5,683	(24,317)
Travel and Transportation	723,607	309,961	18,943	218,242	91,719	505,365
Supplies	13,622	5,788	0	529	5,259	13,093
Contractual	25,672,205	10,756,285	607,276	7,814,932	2,941,353	17,857,273
Other Direct Costs						
Allowances	1,540,397	476,577	45,951	276,261	200,316	1,264,136
Grants	7,500,000	3,269,851	888,938	2,068,450	1,201,401	5,431,550
Special Activities Procurement **	800,000	1,050,000	149,649	956,382	93,618	(156,382)
Special Activities Training	200,000	186,237	33,763	186,237	0	13,763
Other	463,706	103,670	41,514	83,805	19,865	379,901
Total Other Direct Costs	10,504,103	5,086,335	1,159,815	3,571,134	1,515,201	6,932,969
Indirect Costs	2,922,696	1,276,493	126,018	1,013,974	262,519	1,908,722
Subtotal Project Costs	43,378,080	18,969,467	2,135,750	13,785,569	5,183,898	29,592,511
Fixed Fee @ 4%	1,495,123	583,270	49,872	468,685	114,585	1,026,438
<b>Totals</b>	<b>44,873,203</b>	<b>19,552,737</b>	<b>2,185,622</b>	<b>14,254,254</b>	<b>5,298,483</b>	<b>30,618,949</b>

### Notes:

\* Two consultants were hired beginning in May 2011, tied to USAID-approved STTA trips to DRC. Of the total \$24,316.04 reported as consultant fees for the July-Sept11 period on this report, \$12,190 was actually incurred in May/June 2011. This report therefore includes a \$12,190 adjustment of prior reported Salary/Wages expenses, to Consultant Fees.

A ProVIC proposed realigned budget currently pending with USAID includes shifting a small amount of funds in the current award budget to a consultant budget line to cover current/anticipated consultant fees through life of project.

\*\* A ProVIC proposed realigned budget currently pending with USAID includes a shifting of funds in the current award budget to cover current and anticipated procurement through life of project.

\*\*\* Includes all costs booked in PATH's general ledger for the period and used to draw against the ProVIC letter of credit. This does not include project accruals for the period.